

Please return to: AMA ACT, PO BOX 560, CURTIN ACT 2605

Personal Details		
AMA MEMBERSHIP NO.		
GIVEN NAMES		
SURNAME		
ADDRESS		
CITY		
STATE & POSTCODE		D.O.B.
Employment Details		
EMPLOYER	ACT Health	
STAFF NUMBER or AGS NUMBER		
DEPARTMENT		
DEPARTMENT ADDRESS		
ADDRESS OF PAY CENTRE	Health Pay Team 3, C/- 40 Allara Street, CANBERRA CITY ACT 2600	
I, SURNAME		
GIVEN NAMES		

hereby authorise you to deduct from my salary or wages payable, the amount of \$ _____ each fortnight as membership subscriptions to the Australian Medical Association (ACT) Ltd and on my behalf pay any such amounts deducted to the AMA ACT.

Should this amount payable by me to the AMA ACT be altered by reason of any change in the rate of membership subscriptions, then this authority shall extend to and cover the altered contributions to the AMA ACT.

This request is to continue until withdrawn by me in writing.

All amounts remitted on my behalf pursuant to this Authority shall be deemed to be payments to me personally.

I agree not to hold my employer or its employees liable if deductions are not made.

SIGNATURE OF APPLICANT	
DATE	
DATE OF EFFECT	
PAY DEDUCTION CODE	AMA

PRIVACY STATEMENT:

The Australian Medical Association (ACT) Limited supports good privacy practice, and has developed a policy to protect your privacy in compliance with privacy legislation. Our policy informs you:

- That we need your consent to collect information about you;
- Why we need to collect that information;
- How your information will be used by us and to whom we may need to disclose it ;
- That you may discuss any concerns you have about how we handle your information.

Further information on our policy is available on request.

Contact:

Mail: PO Box 560 CURTIN ACT 2605

Phone: 02 6270 5410 Fax: 02 6273 0455

Web: www.ama-act.com.au Email: accounts@ama-act.com.au