

**HEARING AID AUDIOMETRIST SOCIETY OF AUSTRALIA**

P.O. Box 4216  
KINGSTON ACT  
2604

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**APPLICATION FOR MEMBERSHIP**

**APPLICANT'S PERSONAL DETAILS:**

Title: \_\_\_\_\_ If applicable: QP # \_\_\_\_\_

Family name: \_\_\_\_\_

Given names: \_\_\_\_\_ Preferred name: \_\_\_\_\_

Address line 1: \_\_\_\_\_

Address line 2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_

Home phone: ( ) \_\_\_\_\_

Work phone: \_\_\_\_\_

Mobile phone: \_\_\_\_\_

Email: \_\_\_\_\_

Mailing address same as above Yes / No

If no complete mailing address:

Mailing address line 1: \_\_\_\_\_

Mailing address line 2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_

**MEMBERSHIP CATEGORY:**

I wish to apply for:

- Full membership
- Associate membership
- Student membership
- Honorary membership/ Affiliate   
(Need employment history)

**ACADEMIC QUALIFICATIONS:**

Qualification	Institution Completed	Year

I have attached:

A copy of my Certificate IV/Diploma in Hearing Device Prescription and evaluation Audiometry   
**Or**

Evidence of my enrolment in the above course   
**Or**

A Copy of my academic transcript indicating I am entitled To a Diploma in Audiometry or it's equivalent

If you are applying for student membership please identify the name of your supervisor(s).

**Supervisor Name:** \_\_\_\_\_ **Contact phone:** \_\_\_\_\_

**Contact email:** \_\_\_\_\_

**EMPLOYMENT HISTORY:**

<b>Full time or Part Time</b>	<b>Start/End Date</b>	<b>Position</b>	<b>Employer</b>

If part time please indicate number of hours working as an audiometrist each week.

\_\_\_\_\_

Please attach letter(s) of confirmation of employment with you application

**RESPONDING TO THE FOLLOWING IS MANDATORY:**

I \_\_\_\_\_(Print name)

DO / DO NOT (circle one)

Authorise HAASA to provide relevant membership information to the Office of Hearing Services (as required by the provisions of the Memorandum of Understanding)

**Signed:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**DECLARATION:**

I declare that the above information is accurate and true. I acknowledge I may be required to substantiate the information to the Executive. I have read and understand the Code of Ethics of the Hearing Aid Audiometrist Society of Australia and agree to abide by it should my application be successful.

**Signed:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**PAYMENT DETAILS:**

**I would like to pay my membership fees by:**

Cheque (please make cheques payable to HAASA)

Postal/money order

Credit card

*Please note a surcharge of 2.5% will apply to all credit card transactions. Please complete your credit card details below:*

MasterCard/Visa

Card no: \_\_\_\_\_

Expiry date: \_\_\_\_\_

Cardholders name (please print) \_\_\_\_\_

Cardholder's signature: \_\_\_\_\_

Amount: \_\_\_\_\_