ABN
54 008 451 910

RTO Code
91660

Health Information Management Associate of Australia Limited

ORGANISATIONAL MEMBERSHIP NOMINEE

PERSONAL DETAILS

Title: Mr / Mrs / Ms / Miss / Other (please specify) ______________________

First Name: ______________________

Middle Name: ______________________

Surname: ______________________

Date of Birth: ______________________ Gender: Male / Female

Please list at least one email address (Only your Primary Email will be used for eAlerts/eNewsletters)

Primary Email: ______________________

Secondary Email: ______________________

Please list at least one phone number

Home Phone: ______________________ Home Fax: ______________________

Work Phone: ______________________ Work Fax: ______________________

Mobile: ______________________

Address – will be used to send your membership pack, and journal subscription

This is a HOME / WORK address

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Suburb: ______________________ State: ______________________ Postcode: ______________________

Country (if not Australia): ______________________

Membership Services
Locked Bag 2045 North Ryde NSW 1670 Australia
P: +61 (02) 9887 5002 **F:** +61 (02) 9887 5895 **E:** membership@himaa.org.au **W:** www.himaa2.org.au

MEMBERSHIP CATEGORY

Please tick the category of membership you are applying for.

☐	**Full Member** – Individuals who are graduates of HIMAA-accredited HIM university programs **Please attach a photocopy of your HIM degree**
☐	**New Graduate** – Individuals who have graduated from a HIMAA-accredited HIM university course, or a HIMAA Approved Program (HAP) within the past 12 months **Please attach a photocopy of your HIM degree or HAP qualification**
☐	**Senior Associate** – Individuals who are graduates of a HIMAA Approved Program OR have a minimum of five years senior-level experience within the health information industry **Please attach evidence of qualification OR a Resume AND either a Position description OR letter of support provided by a direct manager.**
☐	**Associate** – Individuals involved or interested in the Health Information profession

Have you been a member of HIMAA (or MRA) in the past? Yes / No

If this membership was under a different name please indicate your previous name: ____________________

AGREEMENT

I understand that by joining HIMAA I agree to be bound by the Principles of Professional Practice and Constitution of the Health Information Management Association of Australia Limited.

Signature: ____ Date: ____________________

HIMAA OFFICE USE ONLY

Application received date: ____________________ Membership status: ____________________

Membership category: ____________________ Membership fee: ____________________

Membership Number: ____________________ Website Username: ____________________

Invoiced on: ______________ Invoice Number: ______________ Amount: ______________

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