

AUSTRALIAN INSTITUTE OF MEDICAL AND CLINICAL SCIENTISTS
Fellowship Program Enrolment Form



PERSONAL INFORMATION

Family Name:

Given Name:

Years of Postgraduate Experience:

Discipline for Study:

EMPLOYER DETAILS

Position title and Employer:

CONTACT INFORMATION

Postal address:

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..... Country

Contact telephone numbers and email address:

Mobile:

Home: Work:

E-mail:

TIMEFRAME

Expected timeframe for completion of the Fellowship program:

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MENTOR

Is an AIMS nominated mentor required? Yes No

If No please give details of proposed mentor:

Name:

Position:

Address:

Phone: E-mail:

Note: Applicants are not required to have a mentor, but the Examinations Council strongly recommends this.

SIGNATURE OF CANDIDATE

By enrolling in the AIMS Fellowship program I agree to participate in APACE (or other approved audited CPD recording program). This participation will begin on or before the date my enrolment is accepted. Further, I agree to continue my CPD post-graduation as a condition of maintaining the Fellowship. To view our privacy policy visit: www.aims.org.au/Web/AboutUs/Privacy-Policy

Print Name:

Signature: Date: / /

SUBMIT FORM

Please send this completed enrolment form via post, email or fax to:

Australian Institute of Medical Scientists

PO Box 1911
Milton QLD 4064
AUSTRALIA

Tel: +61 7 3876 2988

E-mail: programs@aims.org.au

OFFICE USE ONLY

ELIGIBLE: YES NO ENTERED: YES NO ACKNOWLEDGED: YES NO