

**FACULTY OF PAIN MEDICINE  
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS**

ABN 82 055 042 852

**APPLICATION TO PRESENT FOR  
FELLOWSHIP OF THE FACULTY OF PAIN MEDICINE EXAMINATION**

SURNAME: .....  
(BLOCK LETTERS)

OTHER NAMES: .....  
(BLOCK LETTERS)

ADDRESS (to which Examination Notices can be sent): .....  
.....  
.....

HAVE YOU REGISTERED FOR TRAINING? .....

HAVE YOU FORWARDED DOCUMENTARY EVIDENCE OF -

(1) QUALIFYING DEGREE OR DIPLOMA.....

(2) MULTIDISCIPLINARY PAIN MEDICINE EXPERIENCE IN ACCORDANCE WITH PROFESSIONAL DOCUMENT PM2?

.....  
(IF NOT, THESE MUST ACCOMPANY THIS APPLICATION)

**I hereby apply to be admitted to the forthcoming Faculty of Pain Medicine, ANZCA Examination and enclose AUD\$4,368 in payment.**

**Signature of Candidate** .....

**Date of Application** .....

**IMPORTANT NOTICE**

This application must be completed and returned to the General Manager, Faculty of Pain Medicine, ANZCA, 630 St Kilda Road, MELBOURNE 3004, together with the examination registration fee. Credit Card facilities, cheques or drafts to be made payable to ANZCA and crossed "Not Negotiable Bank Account Payee Only". See Over

APPROVED ..... ASSESSOR ..... DATE .....

APPLICATION WILL NOT BE ACCEPTED  
WITHOUT PASSPORT QUALITY PHOTOGRAPHS  
ATTACHED TO THIS FORM

**Note Regulation 5.5**

Trainees wishing to present for the Examination are required to:

- 5.5.1 Apply on the approved form
- 5.5.2 Submit the required documents
- 5.5.3 Pay the prescribed training and examination fees
- 5.5.4 Ensure that the above items are received by the Faculty Executive Officer at least 45 days before the commencement date of the examination

ARE YOU OCCUPYING AN APPROVED TRAINING POST? IF SO, AT WHICH HOSPITAL?  
.....



Attach PHOTO Here

**DO NOT cover small boxes at top**

.....  
PRINT NAME

.....  
SIGNATURE



Attach PHOTO Here

**DO NOT cover small boxes at top**

.....  
PRINT NAME

.....  
SIGNATURE

**DETAILS ON REVERSE MUST BE COMPLETED**

**I certify that:**

- (i) I have no illness or disability (including a substance abuse disorder) that would preclude the safe practice of Pain Medicine. I have informed the Faculty of inappropriate use of medications or other substances with the potential to compromise the safe practice. I am receiving appropriate medical care.
- (ii) I undertake to notify the Faculty on the following: - if I develop a substance abuse disorder with recreational prescribed or non-prescribed drugs; if I commence treatment with prescribed drugs with the potential to compromise the safe practice of pain medicine; or if I develop an illness or disability that may preclude the safe practice of pain medicine.
- (iii) Pursuant to 1.3, all communications made by the officers of the Faculty/College, and all answers made are absolutely privileged.

Signature: .....

Date: .....

Bank Draft/Cheque made payable to  
"Australian and New Zealand College of  
Anaesthetists" (ANZCA)

Credit Card  
(please complete details)

<b>CREDIT CARD DETAILS:</b>												
<input type="checkbox"/> Mastercard <input type="checkbox"/> Visa												
Credit Card number												
Expiry Date:    ...../.....												
Name on Card: .....												
Amount Paid: .....												
Signature: .....												