Council Member Nomination Form:
Aboriginal or Torres Strait Islander
registered medical practitioner

# To be considered for the position please complete all sections of this form and return (Word format) to Council@amc.org.au with a copy of your CV by close of business Friday 11 October 2019.

|  |  |
| --- | --- |
| **Name** |  |
| Family Name: |  |
| Given Name/s: |  |
| Title: |  |
| **Gender (please select)** |  |
| Male |  |
| Female |  |
| Other |  |
| **Residential Address** |  |
| No/Street: |  |
| Suburb/Town: |  |
| State |  |
| Postcode |  |
| **Postal Address** |  |
| Postal address:*(if different from above)* |  |
| **Contact details** |  |
| Mobile: |  |
| Business Phone: |  |
| Home Phone: |  |
| Email: |  |
| **Do you identify as belong to one of these groups?** |  |
| Person with a disability |  |
| **Referees**  |  |
| Referee 1 Name:  |  |
| Position & Organisation |  |
| Phone: |  |
| Referee 2 Name:  |  |
| Position & Organisation |  |
| Phone: |  |
| **Formal Qualifications** |  |
| *Please list each qualification on a separate line* |  |
| **Current role and experience**  |  |
| Current role |  |
| Summary of experience |  |
| **Selection Criteria** |  |
| Knowledge of or interest in areas regularly considered by the AMC (health, training and education) |  |
| Why do you wish to be considered for the position? |  |
| **CV** |  |
| Please include a PDF copy of your CV with your submission |  |