

PLACE
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**APPLICATION FORM FOR
MEMBERSHIP OF THE
PACIFIC RIM COLLEGE OF PSYCHIATRISTS**

Please return to:

PRCP Secretariat located at:
University of Melbourne Department of Psychiatry, 1 North, Level 1 Main Block
Royal Melbourne Hospital, Victoria, Australia 3050
Ph: +61 3 8344 5509, Fax: +613 9347 3457, E-mail: info@prcp.org

DATE: _____

TITLE _____ FIRST NAME: _____ LAST NAME: _____

DATE OF BIRTH: _____ COUNTRY: _____ SEX: _____

MEDICAL SCHOOL GRADUATED FROM: _____

YEAR OF GRADUATION: _____

POST GRADUATE (OR RESIDENCY) TRAINING RECEIVED AT: _____

FROM: _____ TO: _____

ARE YOU A MEMBER OF A NATIONAL PSYCHIATRY ORGANISATION? (PLEASE SPECIFY)

SPECIALIST BOARD: DATE RECEIVED: _____

PSYCHIATRY _____

NEUROLOGY _____

OTHER (PLEASE SPECIFY) _____

CURRENT INTERESTS:

CLINICAL _____

TEACHING _____

RESEARCH _____

CROSS CULTURAL _____

CURRENT POSITION: _____

MAILING ADDRESS: _____

HOME PHONE: _____ OFFICE PHONE: _____

FAX: _____ E-MAIL: _____

PLEASE ATTACH CURRICULUM VITAE (abbreviated version acceptable) AND ONE PASSPORT PHOTOGRAPH.

SIGNATURE X _____

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