New Zealand Hospital Pharmacists' Association
Mental Health Special Interest Group (SIG) Meeting
29th and 30th July 2017, Beavan Lecture Theatre, Christchurch School of Medicine, Christchurch Hospital

REGISTRATION FORM

Please complete this form, make a copy for your records, and forward the original with appropriate registration fee to: The Administrator, NZHPA, PO Box 11640, Manners Street, Wellington 6142 (nzhpa@psnz.org.nz; Ph 04 802 0030 ext 2; Fax: 04 381 4786). Invoice/receipt will be sent to you directly.

CONTACT DETAILS (Please print in block capitals)

Surname _____ **NZHPA Membership #** _____

First name / Preferred name _____

Location / Organisation for name badge _____

Full postal address _____

Telephone _____ **Fax** _____

Email _____

Special requirements ***(e.g. dietary, wheelchair access)*** _____

REGISTRATION FEES ($NZ incl GST) **Please tick the appropriate category**	**Full seminar (Sat & Sun)**	**Saturday only (all day)**	**Sunday only (am only)**
NZHPA Mental Health SIG member	$120.00	$70.00	$60.00
NZHPA non Mental Health SIG member	$135.00	$85.00	$70.00
NZHPA Associate members e.g. Students, Intern Pharmacists, Pharmacy Technicians	$95.00	$60.00	$50.00
Non NZHPA member	$150.00	$120.00	$100.00
Registration Fee total (incl GST)			

If registering for day registration only, please specify day of attendance _____

Registrations will not be accepted after 24/07/2016 without prior discussion with the Organising Committee Tom Elliott (Tom.Elliott@cdhb.health.nz)

Payment method

- ❒ Cheque — If paying by cheque please make cheque payable to *NZ Hospital Pharmacists Association*.
- ❒ Direct Credit — Bank account details 01 0505 0224181 00 – if paying by direct credit ensure your name, NZHPA member number and MHSIG Meeting are used as references and that this form is returned for processing (Fax: 04 381 4786). Date paid: _____
- ❒ Credit Card — Paying by: Visa / MasterCard (please circle) For security reasons, please do not email your credit card information to us. Please send any credit card payments by fax or post.

Card Number: | | | | | | | | | | | | | | | | |

Expiry Date: _____ / _____

Name on Card: _____ Signature: _____

SATURDAY EVENING DINNER
Cost **not** included in registration. Partners welcome. Please indicate number attending _____

Privacy: The information supplied on the registration form will be shared and used by the organising committee. If you **do not** wish your name to be included in the list of participants distributed to delegates and sponsors please tick the following box. ❒

Cancellation Policy: We regret that we have to make a charge for cancelled registrations. If you notify us of the cancellation of your reserved place giving six weeks or more prior notice to the event, 25% of the fee will be retained. From six to 3 weeks prior to the event, 50% will be retained. If between three and one week's notice is given of the cancellation for your reserved place, 75% will be retained. There is no refund for non-attendance or cancellations made less than one week (7 days) prior to the event, whereupon the full fee will remain payable. The Association reserves the right to cancel meetings and to return the registration fee. The Association cannot be responsible for any losses resulting from such cancellation, however caused.