



New Zealand Hospital Pharmacists' Association Incorporated
Te Kāhui Whakarite Rongoā Hōhipera o Aotearoa

Membership Application

Please print all details clearly

Name Dr/Mr/Mrs/Ms/Miss

First Name Surname Preferred Name

Position Held if applicable

Hospital or Company Name

Postal Address

(Business is preferred)

Suburb

City

Postcode

Work Phone

Mobile

Home Phone

Date of Birth

Email Address (for Database)

Email Address (for Discussion List)



I do not wish to subscribe to the NZHPA Discussion List (enrolment will be automatic if you do not tick here)

Have you been an NZHPA member previously? Yes / No

Please select your membership category, SIGs and SINS below, indicating the total amount.

1 June to 31 May
Subscription Fee

Ordinary / Fellow - Pharmacist more than 20 hours / week		\$	170.00	\$	_____
Ordinary / Fellow - Pharmacist 20 hours or less / week **		\$	115.00	\$	_____
Ordinary / Fellow - Hospital Pharmacy Technician more than 20 hours / week		\$	115.00	\$	_____
Ordinary / Fellow - Hospital Pharmacy Technician 20 hours or less / week **		\$	85.00	\$	_____
Associate - ⌘ (see below) more than 20 hours / week		\$	75.00	\$	_____
Associate - ⌘ (see below) 20 hours or less / week**		\$	60.00	\$	_____
Corporate		\$	625.00	\$	_____
<i>I would like to join the following...</i>					
Special Interest Groups (SIG)	<input type="checkbox"/> Medicine Info. & Clinical Pharmacy (MICP)	\$	10.00	\$	_____
	<input type="checkbox"/> Compounding, Nutrition & Oncology (CNO)	\$	10.00	\$	_____
	<input type="checkbox"/> Mental Health	\$	10.00	\$	_____
	<input type="checkbox"/> Technicians	\$	10.00	\$	_____
	<input type="checkbox"/> Hospital Pharmacy Managers (I am a Hospital Pharmacy Manager)	\$	10.00	\$	_____
Advisory Group			Total	\$	_____
Special Interest Networks (SIN)	<input type="checkbox"/> Education and Training		No charge		
	<input type="checkbox"/> Infectious Disease/Antimicrobial Stewardship ID/AMS (Must be an MICP SIG member)		No charge		
	<input type="checkbox"/> Cardiology		No charge		
	<input type="checkbox"/> Health Informatics		No charge		
	<input type="checkbox"/> Research		No charge		

⌘ Associate Membership includes: Intern Pharmacist, Undergraduate Pharmacy student, Pharmacy Technician student, Non-Hospital Pharmacy Technician or Non-Pharmacist. Please state: _____

** If applying for a reduced subscription (20 hours/week or less) complete the following:

I declare that I am employed for _____ hours per week.

Signature: _____ Date: _____

Please turn over for payment details

Ethnicity

Which ethnic group do you belong to? *Mark the space or spaces which apply to you.*

- | | | |
|---|---------------------------------|----------------------------------|
| <input type="checkbox"/> New Zealand European | <input type="checkbox"/> Māori | <input type="checkbox"/> Tongan |
| <input type="checkbox"/> Niuean | <input type="checkbox"/> Samoan | <input type="checkbox"/> Chinese |
| <input type="checkbox"/> Cook Island Māori | <input type="checkbox"/> Indian | <input type="checkbox"/> British |
| <input type="checkbox"/> Australian | | |
| <input type="checkbox"/> other such as Dutch, Japanese, Tokelauan. Please state _____ | | |

Are you of Māori descent (Māori birth parent, grandparent or great-grandparent, etc)?

- Yes
- No
- Don't know

Do you know the name(s) of your iwi (tribe or tribes)?

- Yes
- No

If yes, please mark your answer and print the name and home area, rohe or region of your iwi below:

Iwi	Rohe (iwi area)

Signature _____ **Date** _____

All subscriptions are inclusive of GST.

Payment method:

- Direct Credit Bank account details 01 0505 0224181 00 – if paying by direct credit ensure your name and membership number are used as references and that this form is returned for processing (address on reverse). Date Paid: _____
- Bulk payment Payment will be made by _____
- Credit Card Please complete the credit card details below.
For security reasons, please **do not** email your credit card information to us. Please send any credit card payments by post or call with your credit card details.

I am paying by: Visa / MasterCard (please circle)

Card Number:

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 Expiry Date: ____ / ____

Name on Card: _____ Signature: _____

Once complete please return this form with your remittance to:

The Administrator
NZ Hospital Pharmacists' Association
PO Box 11640, Manners Street, WELLINGTON 6142
Phone (04) 802 0030 ext 7 www.nzhpa.org.nz Email: nzhpa@psnz.org.nz