



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

**Membership Application**

- I wish to apply for
- Ordinary Membership
  - Associate Membership
  - Corporate Membership

of the New Zealand Hospital Pharmacists' Association (NZHPA) and I am eligible under the rules printed on the reverse side of this form.

I agree to abide by the Rules of the Association. I am liable for an annual subscription fee until such time as I notify the Secretary, in writing, of my resignation. My membership will cease automatically after any unpaid subscription is due.

*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** \_\_\_\_\_ **Work Fax** \_\_\_\_\_

**Home Phone** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**Mobile** \_\_\_\_\_

**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

**My Annual Subscription is enclosed** (complete form with appropriate category fee, see over for payment methods):

		Subscription Fee 1 Dec to 31 May	
<b>Ordinary / Fellow</b>	- Pharmacist more than 20 hours / week	\$ 75.00	\$ _____
<b>Ordinary / Fellow</b>	- Pharmacist 20 hours or less / week **	\$ 50.00	\$ _____
<b>Ordinary / Fellow</b>	- Hospital Pharmacy Technician more than 20 hours / week	\$ 50.00	\$ _____
<b>Ordinary / Fellow</b>	- Hospital Pharmacy Technician 20 hours or less / week **	\$ 37.50	\$ _____
<b>Associate</b>	- ⌘ (see below) more than 20 hours / week	\$ 32.50	\$ _____
<b>Associate</b>	- ⌘ (see below) 20 hours or less / week**	\$ 25.00	\$ _____
<b>Corporate</b>		\$ 275.00	\$ _____
<b>Special Interest Groups (SIG)</b>	<input type="checkbox"/> Medicine Information & Clinical Pharmacy (MICP)	\$ 10.00	\$ _____
	<input type="checkbox"/> Compounding, Nutrition & Oncology (CNO)	\$ 10.00	\$ _____
	<input type="checkbox"/> Pharmacists in Mental Health	\$ 10.00	\$ _____
	<input type="checkbox"/> Technicians	\$ 10.00	\$ _____
<b>Forums</b>	<input type="checkbox"/> Hospital Pharmacy Managers (DHB lead for Pharmacy)	\$ 10.00	\$ _____
	<b>Total</b>	\$ _____	

⌘ 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: \_\_\_\_\_

All subscriptions are inclusive of GST and are set annually at the NZHPA Annual General Meeting.

Please turn over

## 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 Maori  | <input type="checkbox"/> Indian |                                  |
| <input type="checkbox"/> other such as Dutch, Japanese, Tokelauan. Please state _____ |                                 |                                  |

Are you descended from a Māori (that is, did you have a 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 \_\_\_\_\_

## 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 and membership number are used as references and that this form is returned for processing (address on reverse). Date Paid: \_\_\_\_\_
- 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.

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

Card Number: 

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 Expiry Date: \_\_\_\_ / \_\_\_\_

Name on Card: \_\_\_\_\_ Signature: \_\_\_\_\_

- Bulk payment Payment will be made by \_\_\_\_\_

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 8 [www.nzhpa.org.nz](http://www.nzhpa.org.nz) Email: [nzhpa@psnz.org.nz](mailto:nzhpa@psnz.org.nz)**

## RULES

The Association shall consist of the following classes of members:

### 5.1 Ordinary Member

Being a member as defined in Clauses 4.1 (Any Pharmacist and Hospital (District Health Board or private hospital) Pharmacy Technician who espouses the objectives of the Association) who has not been admitted as a Fellow.

### 5.2 Fellow

5.2.1 A member with 15 years experience in hospital pharmacy or clinical pharmacy practice may on application be admitted as a Fellow where in the opinion of the Executive this is merited.

Application in writing must be made to the Secretary. Copies of published work or thesis related to hospital pharmacy or clinical pharmacy practice must accompany the application.

5.2.2 A member may be elected a Fellow at an Annual General Meeting on the recommendation of the Executive, in recognition of distinguished service to the profession of hospital pharmacy or in clinical pharmacy practice.

5.2.3 A Fellow may use the designation FHPA after his or her name on documents.

### 5.3 Associate Member

5.3.1 A Pharmacist who is non-practicing or overseas, an Intern Pharmacist, non-Hospital Pharmacy Technician, Undergraduate Pharmacy Student, Student Pharmacy Technician or a non-pharmacist who espouses the objectives of the Association may be admitted as an Associate Member at the discretion of the Executive.

5.3.2 An Associate Member shall be liable for an annual subscription and have the right to attend and speak at any General Meeting of the Association, but shall not be entitled to vote or hold office.

### 5.4 Corporate Member

5.4.1 An organisation, which has an association with, or an interest in hospital pharmacy or clinical pharmacy practice, may be admitted as a Corporate Member at the discretion of the Executive.

5.4.2 A Corporate Member shall be liable for an annual subscription and shall have the right to have a representative attend and speak at any General Meeting of the Association, but a representative of a Corporate Member shall not be entitled to vote or hold office.