



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

Membership Application

I wish to apply for 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

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

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

6-month Subscription Fee 1 December to 31 May

Ordinary / Fellow	- Pharmacist more than 20 hours / week	\$	75.00	\$ _____
Ordinary / Fellow	- Pharmacist 20 hours or less / week **	\$	50.00	\$ _____
Ordinary / Fellow	- Hospital Pharmacy Technician more than 20 hours / week	\$	50.00	\$ _____
Ordinary / Fellow	- Hospital Pharmacy Technician 20 hours or less / week **	\$	37.50	\$ _____
Associate	- ⌘ (see below) more than 20 hours / week	\$	32.50	\$ _____
Associate	- ⌘ (see below) 20 hours or less / week**	\$	25.00	\$ _____
Corporate		\$	275.00	\$ _____

I would like to join the following...

Special Interest Groups (SIG)	<input type="checkbox"/> Medicine Information & 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	\$ _____
Advisory Group	<input type="checkbox"/> Hospital Pharmacy Managers (I am a Hospital Pharmacy Manager)	\$	10.00	\$ _____
	Total			\$ _____

Special Interest Networks (SIN)	<input type="checkbox"/> Education and Training	No charge
	<input type="checkbox"/> Infectious Disease/Antimicrobial Stewardship ID/AMS (Must be a member of MICP SIG)	No charge
	<input type="checkbox"/> Cardiology	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: _____

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

Please turn over for payment

Ethnicity

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

- New Zealand European
- Niuean
- Cook Island Maori
- Other such as Dutch, Japanese, Tokelauan. Please state _____
- Māori
- Samoan
- Indian
- Tongan
- Chinese

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 Email: 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.