



**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) _____	
<input type="checkbox"/> 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	
<b>Ordinary / Fellow</b> - Pharmacist more than 20 hours / week	\$	150.00	\$	_____
<b>Ordinary / Fellow</b> - Pharmacist 20 hours or less / week **	\$	100.00	\$	_____
<b>Ordinary / Fellow</b> - Hospital Pharmacy Technician more than 20 hours / week	\$	100.00	\$	_____
<b>Ordinary / Fellow</b> - Hospital Pharmacy Technician 20 hours or less / week **	\$	75.00	\$	_____
<b>Associate</b> - ⌘ (see below) more than 20 hours / week	\$	65.00	\$	_____
<b>Associate</b> - ⌘ (see below) 20 hours or less / week**	\$	50.00	\$	_____
<b>Corporate</b>	\$	550.00	\$	_____
<i>I would like to join the following...</i>				
<b>Special Interest Groups (SIG)</b>	<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 \$ _____
<b>Advisory Group</b>	<input type="checkbox"/>	Hospital Pharmacy Managers (I am a Hospital Pharmacy Manager)	\$	10.00 \$ _____
		<b>Total</b>	\$	_____
<b>Special Interest Networks (SIN)</b>	<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 Maori  | <input type="checkbox"/> Indian | <input type="checkbox"/> British |
| <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 and are set annually at the NZHPA Annual General Meeting

### 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 or call with your credit card details.

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

Card Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

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)