



**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.

6-month Subscription Fee  
1 December 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	\$ _____
<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**

