MEMBERSHIP APPLICATION





PHARMACEUTICAL SOCIETY

of New Zealand Incorporated

PLEASE COMPLETE BOTH SIDES OF THIS APPLICATION FORM AND RETURN VIA:

Post to: or Email to: Enquiries: PSNZ Inc, PO Box 11640, Manners Street, Wellington 6142 p.society@psnz.org.nz 04 802 0030

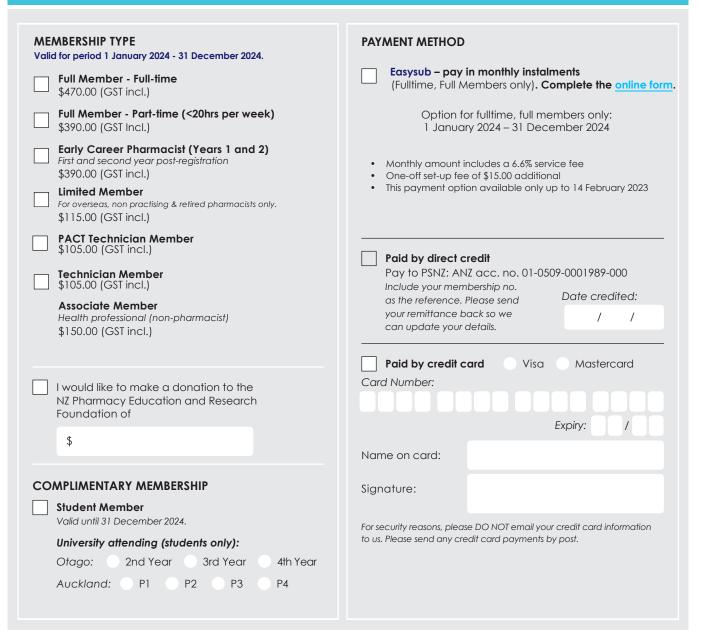
01. YOUR DETAILS

Please complete the following information.						
Title (Mr, Mrs, Dr etc)						
Surname						
First Name/s (legal name)						
Preferred Name						
Pharmacy Council Number						
PSNZ Number (if known)						
Preferred Mailing Address Details	Street:					
Address Defails	Suburb:					
City & Postcode:						
OR Pharmacy Name (if applicable):						
PO Box / Street & Suburb:						
City & Postcode:						
Work Phone						
Work Fax						
Home Phone						
Mobile						
E-mail (preferred)						
Date of Birth						
Gender		Male	Female	Other		
Place of Employment (Pharmacy name or comp	any)					
Pharmacy Qualifications						
Ethnicity*						

* This question provides statistics for research and development. You do not have to answer if you do not want to.

CONTINUED

02. MEMBERSHIP PARTICULARS



03. TERMS AND CONDITIONS OF MEMBERSHIP

Membership of Pharmaceutical Society of New Zealand Incorporated is subject to our terms of trade and privacy policy, available on our website at www.psnz.org.nz. By ticking this box you confirm that you have read and understood our terms of trade and privacy policy. The membership period and associated fee on this form are for the calendar year from 1 January 2024 to 31 December 2024, regardless of the date on which the fee is paid or a direct debit contract is entered into. Membership will not be granted to you unless and until payment is received by us from you in full, or in the case of payment by instalments, until your first instalment payment is received by us from you. In the event that you fail to make an instalment payment on the required date for payment of an instalment, we reserve the right to cancel your membership.