



# NZCP Membership Form

Mr / Miss / Mrs / Ms / Dr \_\_\_\_\_

Postal Address \_\_\_\_\_

Place of Employment \_\_\_\_\_ Fax ( ) \_\_\_\_\_

Telephone Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_

PSNZ Membership No \_\_\_\_\_ E-mail \_\_\_\_\_

|   |       |
|---|-------|
| I am not a member of the College for 2010 and wish to join: | \$155 |
|---|-------|

Please check our website regularly for course updates: [www.psnz.org.nz](http://www.psnz.org.nz) – select “College”

## PAYMENT OF FEES

**CHEQUE**

I have enclosed a cheque made payable to the New Zealand College of Pharmacists \$

**DIRECT TRANSFER** Date paid: \_\_\_\_\_

Account details: **01-0509-0101250-00** - NZ College Of Pharmacists Inc.

(Please ensure you use your **PSNZ or Council Membership No** AND “**NZCPFEES**” as reference codes)

**CREDIT CARD**

I wish to pay by credit card (please provide details below)

Visa  Mastercard

Card Number: \_\_\_\_\_

Name on card: \_\_\_\_\_

Expiry Date: \_\_\_\_\_ / \_\_\_\_\_ Total amount to be charged: \$ \_\_\_\_\_

Signature: \_\_\_\_\_

## DECLARATION

1 **Requirements for membership of the College (Associates, Members and Fellows)**

I hereby undertake to complete at least 25 hours of pharmacy-related continuing professional development during the year 1 January to 31 December.

2 **Privacy Act 1993**

I understand that the personal information I have provided allows the New Zealand College of Pharmacists (NZCP) to carry out its purpose as a provider of education and training and this is covered by the Privacy Act 1993. I am aware that this information is collected and used by appropriate staff at NZCP involved in the administration of my enrolment and in the teaching, assessing or researching of the academic programme of study I have chosen. I also authorise selected categories of this information (name, contact and academic details) being disclosed to supporters of Membership modules (eg University of Otago's Distance Learning Unit, NZCP Executive Council).

I do not object to my name being published in a list of successful candidates.

I am also aware that I am able to have access to the information held on me and that this information can be corrected at any time at my request.

3 I verify that all the information shown on this form is complete and correct.

### Sign

(Applicant's Signature) \_\_\_\_\_

(Date) \_\_\_\_\_

### OFFICE USE ONLY

- CBA
- ACCESS
- CERT

Please ensure all details are complete. Return this form with your remittance to:

New Zealand College of Pharmacists, PO Box 11-640, WELLINGTON  
Telephone: (04) 802-0030, Facsimile (04) 381 4786 or Email: [nzcp@psnz.org.nz](mailto:nzcp@psnz.org.nz)