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 2008 and wish to join:	$150

Please check our website regularly for course updates: 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