

MEMBERSHIP APPLICATION



PHARMACEUTICAL SOCIETY
of New Zealand Incorporated

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

Post: PSNZ Inc, PO Box 11640, Manners Street, Wellington 6142

or Fax: 04 382 9297 | Enquiries: 04 802 0030

01. YOUR DETAILS

Title (Mr, Mrs, Dr etc)	
Surname	
First Names	
Preferred Name	
Pharmacy Council No.	
PSNZ number (if known)	
Mailing Address Details	
Work Phone	()
Work Fax	()
Home Phone	()
Mobile	()
E-mail	
Date of Birth	
Gender	M / F
Place of Employment	
Pharmacy Qualifications	
Ethnicity*	

* This question provides statistics for research and development. You do not have to answer if you do not want to. Please use one of the following descriptions: African, Australian, Chinese, Cook Island Maori, Fijian, Indian, Latin American/Hispanic, Middle Eastern, Niuean, NZ European, NZ Pakeha, NZ Maori, Pacific Island, Samoan, Tokelauan, Tongan, other – please specify (e.g. European, Asian, Pacific Island).

Please turn over to complete final sections

