

# TRAINEE TECHNICIANS 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

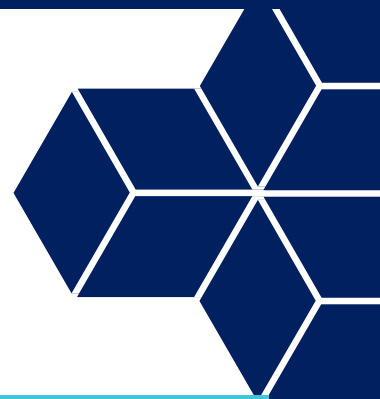
Please complete the following information.

Title (Mr, Mrs, Dr etc)	
Surname	
First Names	
Preferred Name	
PSNZ Number (Office use only)	
Preferred Mailing Address Details	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
Work Phone	(    )
Work Fax	(    )
Home Phone	(    )
Mobile	(    )
E-mail	
Date of Birth	
Gender	M (    )    F (    )
Place of Employment (Pharmacy)	
Pharmacy Qualifications	
Education Provider	
Ethnicity*	

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

Please turn over to complete the final 2 sections

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## 02. MEMBERSHIP PARTICULARS

### EMPLOYER DETAILS

Supervising Pharmacist	
Pharmacy	
Contact Phone	
Email Address	
Pharmacist Registration #	

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

Pharmacist Signature \_\_\_\_\_

Date: \_\_\_\_\_

### COMPLIMENTARY MEMBERSHIP

Trainee Technician Member

## 03. PRIVACY STATEMENT

The Pharmaceutical Society of New Zealand Inc (“the Society”) is collecting this information from you for the purposes of granting you membership and for the administration of contact information for the Membership of the Society. This information will be held by the Society at our offices at Level 10 Grand Arcade Tower, 16-20 Willis Street, Wellington. We will not use or disclose your personal information except in accordance with the Privacy Act 1993.

Under the Privacy Act 1993, you have the right to access or correct any personal information we hold about you. By signing this application form you acknowledge that you have read and understood this privacy statement and your rights contained within it.

Signed: \_\_\_\_\_ Date:    /    /