



MEMBERSHIP APPLICATION FORM

Title: _____ First Name: _____ Surname: _____

Clinic Name: _____

Clinic address: _____

Business Ph: _____ Business Fax: _____

Home Address: _____

Home Ph: _____ Mobile: _____

Address for Correspondence (please circle): Business / Home

Website: _____ Email: _____

Skype user name: _____ Skype address: _____

Medical Qualification: _____

Year qualified: _____ Country: _____

NZ Medical Council Number: _____

Fees on Application (Incl. GST)

GST 78-878-266

Application Fee (non-refundable) \$1125.00

Annual Subscription & Training Fees are invoiced on acceptance

Enclose the following current documents (please tick):

Curriculum Vitae Annual Practising Certificate

FRNZCGP Certificate of Good Standing

Proof of Medico legal protection (MPS or similar)

Post these documents and a **cheque payable to 'NZCAM' for \$1125.00** to the Administrator at the address below.

Applications will not be processed until all documentation is received.

Signed: _____ Date: _____