The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

Membership application form

ASSOCIATE MEMBERSHIP / REJOINING

Thanks for applying to join The Royal New Zealand College of General Practitioners. Before completing this form, please take a moment to read the information on **membership categories and fees** in the Membership section of our website.

Please email, post or fax your completed application form to:

The Royal New Zealand College of General Practitioners
P O Box 10440, Wellington 6143, New Zealand
Email: **membership@rnzcgp.org.nz** | Fax: +64 4 496 5997

If you are uncertain about any aspect of this application, please call +64 4 496 5999.

Please include a current Certificate of Professional Status from the Medical Council of New Zealand.

For which of the following are you applying:

☐ Associate membership ☐ I am rejoining

Title: Surname: First names:

Preferred name: Gender: ☐ Male ☐ Female

Date of birth (DD / MM / YYYY): / / Ethnicity:

Preferred email address (individual):

Home address:

City: Postcode:

Phone: ( ) Mobile: Fax: ( )

Practice name:

Practice address:

City: Postcode:

Phone: ( ) Fax: ( )

Preferred postal address: ☐ Home ☐ Practice

Academic background	Date	Qualification	University / college / country
Primary qualification			
Other medical qualifications			
Non-medical qualifications			

Medical registration:

Date of registration in New Zealand: MCNZ reg. no:

Type of registration: ☐ Provisional ☐ General ☐ Vocational ☐ Other (please specify):

Please briefly explain your reasons for applying for membership:

If you are rejoining, please outline the medical-related work and activities you have been involved in since leaving the College:

Do you consider yourself 'engaged in general practice and/or working in a rural hospital'?	☐ Yes	☐ No
If you answered 'No', are you intending to be engaged in this work?	☐ Yes	☐ No

What are your present positions or appointments in all fields and how is your time divided (in tenths of a working week to a maximum of 10 tenths):

Would you like to be part of the **Rural General Practitioners' Chapter**?	☐ Yes	☐ No
Would you like to be part of **The Division of Rural Hospital Medicine**?	☐ Yes	☐ No
Would you like to be part of the **Registrars' Chapter**?	☐ Yes	☐ No
Would you like to be part of the **Pacific Chapter**?	☐ Yes	☐ No

If you are of Māori descent, would you like to join, or learn more about, the representative group **Te Akoranga a Māui**?	☐ Yes	☐ No

Terms and conditions

- By becoming a member of the RNZCGP, you agree to uphold and promote the objects of the College.
- As a member, you agree to abide by the **RNZCGP Rules**.
- You agree to keep the RNZCGP informed of any changes of address and other contact information and of changes in your position or employment.
- Submitting this application means you accept liability for the subscription payment once invoiced. RNZCGP membership is individual and membership remains with you, regardless of your employment or who funds your membership.
- Your RNZCGP membership commences on the date your application is accepted and your fees will cover the period until the following 31 March, at which time you will be invoiced for the next year's fees at the rate then applying, unless you formally resign your membership. Should you resign, all outstanding fees and levies must be paid in full.

☐ I accept the membership terms and conditions.

☐ I have attached/included a current Certificate of Professional Status from the Medical Council of New Zealand.

☐ I declare that the information I have provided in this application is correct.

Signature of applicant: *(or signed electronically)* **Date:**

Thank you for taking the time to fill in this form. The information you have provided will enable us to assess whether you meet the College's membership criteria. We will email you to acknowledge your application and, if accepted, you will receive membership information and an invoice for your subscription fees.

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