



Membership Form 2007/2008

Title:		
Surname:		
First Name:		
Address:	<i>Home:</i>	
	<i>Business:</i>	
Telephone:	<i>Home:</i>	
	<i>Business:</i>	
Cellphone:		
Fax:		
Email:		
Qualification(s):		
Current Positions Held:		
Past Positions Held:		
Awards:		
Student membership: <i>(Please insert Student ID Number)</i>	\$30.00 <input type="checkbox"/>	Student ID Number:
Full member	\$150.00 <input type="checkbox"/>	
Type of subscription:		

Please pay by:

Cheque posted to:

Pasifika Medical Association
PO Box 23-061
Hunter's Corner
Auckland
NEW ZEALAND

*Or by **Direct Credit** into:*

Pasifika Medical Association **Account No. 12-3086-0178451-00**
ASB Bank, Meadowbank, **AUCKLAND**

ETHICS STATEMENT

“The Privacy Act 1993 determines how we collect, use, hold, disclose, access, correct, manage and dispose of your personal information. The information you provide to the Pasifika Medical Association will be held confidential unless you authorize it and will not be shared with any organisation. The information you provide may be used in a non identifiable format to provide aggregated data for the purposes of supporting the aims of the organisation including the development of a Pacific Health workforce. You may at anytime review the information held about you by contacting the Administrator Pasifika Medical Association.”

“The Ministry of Health New Zealand has requested access to member information for the purposes of publication mail out, invitation to participate in sector based activities, nomination for working parties or committees.” Please check the following boxes for authorization.

- I authorize Pasifika Medical Association to provide my contact details, name, address, telephone and email contact numbers to the Ministry of Health for the purposes of participation in sector based activities.
- I DO NOT authorize Pasifika Medical Association to provide my contact details to the Ministry of Health.