



Membership Application

Please complete and post or fax to:

Pharmacy Defence Association of New Zealand Inc.
PO Box 11640
Manners Street
Wellington 6142

Phone (04) 802 0030
0800 PDA HELP 0800 732 4357
Fax (04) 802 8208
email: pda@psnz.org.nz

NON-PROPRIETOR PHARMACIST

Membership entitles you to assistance with professional indemnity and public liability issues.

Pharmacy Council Registration Number: _____ Date of Birth: _____

PSNZ Number: _____

Full Name: Mr, Mrs, Ms, _____
Miss, Dr, etc _____

Postal Address: _____

Email: _____

Telephone Number: Bus. () _____ Fax Number: Bus. () _____

Hm. () _____ Mobile: _____

Annual Membership fee \$190.00 including GST. Membership is from 1 January to 31 December.

A pro rata membership for six months, valid from date of receipt of application is available at \$110.00 incl GST.

Please pay directly into the Pharmacy Defence Association account; ANZ, Manners Street Wellington, account number 010509 0206255 00, please use your PSNZ number as a reference or attach a cheque made payable to the 'Pharmacy Defence Association of NZ Inc.'

or enter your credit card details here:

Date Direct Credited

____/____/____

Please charge my Mastercard Visa

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Name on Card _____

Signature _____

Expiry Date ____/____

TO BE COMPLETED WITH ALL APPLICATIONS

Please accept this as my application to join the Pharmacy Defence Association. I agree to be bound by the Rules of Membership (obtainable on application).

Signature _____ Date _____

In order to meet the requirements of the Association's insurer, all Pharmacy Defence Association members and first time applicants, **must** complete the declaration form accompanying this application.