TRAINEE TECHNICIANS MEMBERSHIP APPLICATION

PHARMACEUTICAL SOCIETY
of New Zealand Incorporated

PLEASE COMPLETE BOTH SIDES OF THIS APPLICATION FORM AND RETURN VIA:
Email: p.society@psnz.org.nz or
Post: PSNZ Inc, PO Box 11640, Manners Street, Wellington 6142
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	
Work Phone	
Work Fax	
Home Phone	
Mobile	
E-mail	
Date of Birth	
Gender	Male ◯ Female ◯
Place of Employment (Pharmacy)	
Pharmacy Qualifications	
Education Provider	
Date Training Commenced	
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

02. EMPLOYMENT DETAILS

EMPLOYER DETAILS

Supervising Pharmacist	
Pharmacist Registration #	
Pharmacy	
Contact Phone	
Email Address	

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 12, Grand Arcade Tower, 18 Willis Street, Wellington. We will not use or disclose your personal information except in accordance with the Privacy Act 2020.

Under the Privacy Act 2020, 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: / /