

Membership application form

MEMBERSHIP DETAILS

Pharmacy name _____

Trading name _____

Street address _____

Postal address _____

Phone _____ Fax _____

Email(s) _____ Email addresses will not be published or sold.

Password _____ Please nominate a password for our website.

Pharmacist licence holder(s) (collective holder(s) of not less than 51% of equity in the pharmacy):

1 _____

2 _____

3 _____

List the pharmacist and pharmacy name of those that hold an interest of more than 10% in another pharmacy:

1 _____

2 _____

3 _____

Nominee's declaration:

I apply for full membership of the Pharmacy Guild of New Zealand (Inc) and I agree to be bound by the rules of membership. Please visit www.pgnz.org.nz/assets/Uploads/Pharmacy-Guild-Rules.pdf for a copy of the Guild Rules.

Signed _____ Date _____

MEMBERSHIP FEES

After being invoiced, I agree to pay Guild membership fees by the 20th of the following month, from the date of invoice.

Method of payment Direct Debit (form will be posted) Direct Credit 01-0517-0002404-000 Cheque

Frequency of payment Monthly Quarterly Yearly

Please fax completed form to 0800 748 453

Dedicated to member pharmacies

