



# Membership Form

## For Office Use Only

Entered on to RE - any missing data requested		Membership card sent	
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## Membership Type (please select which type of member you wish to be)

<b>General Member</b> (Over 25 years of age with voting rights)		<b>Young Member</b> (Aged between 16 and 25 years with the additional right to vote for a young representative on the National Council)	
<b>Child / Nga Taitamariki</b> (Under 16 years of age, with no voting rights)		<b>Friend of the Association</b> (interested in receiving information but no voting rights)	

## Please complete the member details below:

<b>First name(s)</b>				
<b>Family name</b>			<b>Title (Mr/Mrs)</b>	
<b>Gender (Male / Female)</b>			<b>Date of birth</b>	
<b>Ethnicity - please select the ethnicity that is most appropriate for you</b>	NZ European	Maori	Pacific Islander	Chinese
	Indian	Other:		
<b>How did you hear about us?</b>				
<b>Address</b> (Including house number)				
<b>Suburb</b>		<b>Postcode</b>		
<b>City</b>		<b>Mobile</b>		
<b>Home Phone</b>				
<b>Email Address</b>			<b>No</b>	
<b>Please tick box if you are happy to be contacted via email</b>	Yes			
<b>Are you a Health Professional?</b>	If yes what type?			

## Do you have a neuromuscular condition, if yes please complete the details below:

<b>Neurologist (Current)</b>			
<b>Date of Diagnosis</b>		<b>NHI Number</b>	
<b>Diagnosis</b>			
<b>General Practitioner (Current)</b>			
<b>Address</b>			
<b>Suburb</b>		<b>City</b>	
<b>Postcode</b>		<b>Phone</b>	
<b>Fax</b>		<b>Email</b>	

If there are any additional family members who are living with a neuromuscular condition please enter the details below:

First name(s)		Family name	
What is your relationship (e.g. brother; sister)			

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Are you the carer for a person with a neuromuscular condition or the parents/guardian for a child under the age of 16 years, if so please enter your details below:

First name(s)		Family name	
Address (Including house number)			
Suburb			
City		Postcode	
Home Phone		Mobile	
Email			
Relationship (How are you related to them)			

The above information is accurate. I understand that this and other information provided to the Muscular Dystrophy Association of NZ will be kept confidentially in accordance with the Privacy Act 1993 and the Health and Information Privacy Code 1994.

Signature		Date	
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## Support Networks

Support Networks consist of people with similar circumstances or problems who come together to share their experiences and provide each other with emotional and moral support in addition to practical advice and information. By bringing together people with common experiences and concerns, support networks can provide an invaluable addition to medical care.

The Muscular Dystrophy Association of New Zealand Support Network has over 400 members throughout New Zealand who are willing to be in touch with others. If you would like to communicate with or meet other people through the Muscular Dystrophy Association please tell us what contact details you grant the Muscular Dystrophy Association to share with other members of the Muscular Dystrophy Association of New Zealand.

If you have any queries or would like the information on starting up a support group please contact us on (09) 815 0247 or (0800) 800 337 if your calling outside the Auckland free calling area.

I \_\_\_\_\_ grant permission for the Muscular Dystrophy Association of New Zealand to share my contact details as listed above, with other members of the Muscular Dystrophy Association of New Zealand, Support Network. I understand that my details will be kept confidentially in accordance with the Privacy Act 1993.

SIGNATURE \_\_\_\_\_

DATE .....

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Branch / National Office sent details		Comments	
Support Network signed National Office sent details		Health Info Release Form	
Donation received		Receipt sent to member	