Muscular Dystrophy New Zealand

Members Reimbursement Form

Agreement

I acknowledge that I am applying to MDANZ for payment of costs to the value of $..... for the pneumonia vaccine.

I confirm that these costs were incurred for the stated purpose (above) and attach evidence of this expenditure.

I agree to have my information used in publicity and promotional material and/or financial reports as required by MDANZ.

Applicant Name: .....

Member Number: .....

If signed on behalf of, signed by: .....

Relationship: .....

Signature.....

My nominated bank account to be credited (please return evidence of payment made with this acknowledgement):

Account Name: .....

Account Number: .....

OR

Medical Centre Name to be paid directly: .....

Invoice number (please supply invoice with this acknowledgement): .....

Note: Payment will be made within five working days from receipt of your acknowledgement

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Charity Registration Number CC31123