



## ENROLMENT FORM

Fields shaded are compulsory

EDI: **quaypark**  
GP2GP: **Dr Karen Napier** MCNZ: **37281**

NHI (Office use only)

Name	(Title)	Given Name	Other Given Name(s)	Family Name
<b>Other Name(s)</b> (eg. maiden name) Please tick the name you prefer to be known as				
<b>Birth Details</b>				
Day / Month / Year of Birth		Place of Birth		Country of birth
<b>Gender</b>				
<input type="checkbox"/> Male		<input type="checkbox"/> Female		<input type="checkbox"/> Gender diverse (please state)
				Occupation

<b>Usual Residential Address</b>	House (or RAPID) Number and Street Name	Suburb/Rural Location	Town / City and Postcode
<b>Postal Address</b> (if different from above)	House Number and Street Name or PO Box Number	Suburb/Rural Delivery	Town / City and Postcode

<b>Contact Details</b>	Mobile Phone	Home Phone	Email Address
<b>Emergency Contact</b>	Name	Relationship	Mobile (or other) Phone

<b>Transfer of Records</b>	<i>In order to get the best care possible, I agree to the Practice obtaining my records from my previous Doctor. I also understand that I will be removed from their practice register.</i>		
	<input type="checkbox"/> Yes, please request transfer of my records	<input type="checkbox"/> No transfer	<input type="checkbox"/> Not applicable
	Previous Doctor and/or Practice Name		Address / Location

<b>Ethnicity Details</b> Which ethnic group(s) do you belong to? <i>Tick the space or spaces which apply to you</i>	<input type="checkbox"/> New Zealand European	<b>Community Services Card</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	<input type="checkbox"/> Maori					
	<input type="checkbox"/> Samoan	Day / Month / Year of Expiry	Card Number			
	<input type="checkbox"/> Cook Island Maori	<b>High User Health Card</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	<input type="checkbox"/> Tongan					
<input type="checkbox"/> Niuean						
<input type="checkbox"/> Chinese						
<input type="checkbox"/> Indian						
<input type="checkbox"/> Other (such as Dutch, Japanese, Tokelauan). Please state						
		<b>Please forward records to us at:</b>				
		EDI: <b>quaypark</b>				
		GP2GP: <b>Dr Karen Napier</b> MCNZ: <b>37281</b>				

## My declaration of entitlement and eligibility

<b>I am entitled to enrol</b> because I am residing permanently in New Zealand. <i>The definition of residing permanently in NZ is that you intend to be resident in New Zealand for at least 183 days in the next 12 months</i>	<input type="checkbox"/>
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**I am eligible to enrol** because:

a	<b>I am a New Zealand citizen</b> <i>(If yes, tick box and proceed to I confirm that, if requested, I can provide proof of my eligibility below)</i>	<input type="checkbox"/>
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If you are **not a New Zealand citizen** please tick which eligibility criteria applies to you (b–j) below:

b	I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010)	<input type="checkbox"/>
c	I am an Australian citizen or Australian permanent resident AND able to show I have been in New Zealand or intend to stay in New Zealand for at least 2 consecutive years	<input type="checkbox"/>
d	I have a work visa/permit and can show that I am able to be in New Zealand for at least 2 years (previous permits included)	<input type="checkbox"/>
e	I am an interim visa holder who was eligible immediately before my interim visa started	<input type="checkbox"/>
f	I am a refugee or protected person OR in the process of applying for, or appealing refugee or protection status, OR a victim or suspected victim of people trafficking	<input type="checkbox"/>
g	I am under 18 years and in the care and control of a parent/legal guardian/adopting parent who meets one criterion in clauses a–f above <b>OR</b> in the control of the Chief Executive of the Ministry of Social Development	<input type="checkbox"/>
h	I am a NZ Aid Programme student studying in NZ and receiving Official Development Assistance funding (or their partner or child under 18 years old)	<input type="checkbox"/>
i	I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme	<input type="checkbox"/>
j	I am a Commonwealth Scholarship holder studying in NZ and receiving funding from a New Zealand university under the Commonwealth Scholarship and Fellowship Fund	<input type="checkbox"/>

<b>I confirm</b> that, if requested, I can provide proof of my eligibility	<input type="checkbox"/>	Evidence sighted <i>(Office use only)</i>
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## My agreement to the enrolment process

**NB. Parent or Caregiver to sign if you are under 16 years**

**I intend to use this practice** as my regular and on-going provider of general practice / GP / health care services.

**I understand** that by enrolling with **THE DOCTORS QUAYMED WYNYARD** I will be included in the enrolled population of **National Hauora Coalition**, and my name address and other identification details will be included on the Practice, PHO and National Enrolment Service Registers.

**I understand** that if I visit another health care provider where I am not enrolled I may be charged a higher fee.

**I have been given information** about the benefits and implications of enrolment and the services this practice and PHO provides along with the PHO's name and contact details.

**I have read and I agree** with the Use of Health Information Statement. The information I have provided on the Enrolment Form will be used to determine eligibility to receive publicly-funded services. Information may be compared with other government agencies, but only when permitted under the Privacy Act.

**I understand** that the Practice participates in a national survey about people's health care experience and how their overall care is managed. Taking part is voluntary and all responses will be anonymous. I can decline the survey or opt out of the survey by informing the Practice. The survey provides important information that is used to improve health services.

**I agree** to inform the practice of any changes in my contact details and entitlement and/or eligibility to be enrolled.

<b>Signatory Details</b>	Signature	Day / Month / Year	<input type="checkbox"/> Self Signing	<input type="checkbox"/> Authority
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**An authority has the legal right to sign for another person if for some reason they are unable to consent on their own behalf.**

<b>Authority Details</b>	Full Name	Relationship	Contact Phone
<i>(where signatory is not the enrolling person)</i>	Basis of authority (e.g. parent of a child under 16 years of age)		
<b>Authority Details</b>			