

# NEW ZEALAND AFFILIATE MEMBERSHIP APPLICATION FORM



*This application form is to be completed personally by the applicant. Details should be typewritten or printed clearly.*

## APPLICANT DETAILS

Last Name: .....  
First Name: .....  
Middle Name/s: .....  
Preferred Postal Address: .....  
.....  
City: ..... Postcode: .....  
Home Phone: ..... Mobile: .....  
E-mail: .....  
Date of Birth: .....  Male  Female  
Employer: .....  
Work Phone: .....

**PROPOSED BY** *(Please print clearly)* \_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_

**SECONDED BY** *(Please print clearly)* \_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_

**\* Please note that either the proposer or the seconder must be a RANZCP Fellow.**

Please indicate if you are of Aboriginal, Torres Strait Islander or Maori origin  
 Aboriginal  Torres Strait Islander  Maori

## DECLARATION

I am currently a Vocationally Registered Psychiatrist (Specialist Psychiatrist) working in New Zealand. I understand that my Affiliateship to the RANZCP will be effective only whilst I remain resident in New Zealand. I am not currently, or likely to be, subject to any investigation into my clinical practice as a result of a complaint, or for any other reason, in New Zealand or any other country.

I solemnly affirm that, if accepted as an Affiliate in New Zealand of The Royal Australian and New Zealand College Psychiatrists, I shall promote the objects of this College to the best of my ability. I admit that I am bound by the Constitution of this College and the By-laws for the time being in force. I promise to obey these, and regulations made there under, in spirit as well as in the letter, submitting myself to the lawful authority of the Board. I pledge myself, in the practice of Psychiatry, ever to have regard to the highest standards of professional service to patients and to the honour of the College.

If I am found in breach of the College code of conduct or code of ethics, my Affiliate status may be withdrawn without reimbursement of fees.

Applicant's signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please return the form, along with your current CV to:**

Royal Australian and New Zealand College of Psychiatrists; Box 10669; Wellington 6143; New Zealand  
Telephone: +64 4472 7247 Fax: +64 4472 7246 Email: [nzoffice@ranzcp.org](mailto:nzoffice@ranzcp.org)