

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:

Man Woman

Non-binary / gender diverse

My gender isn't listed, I identify as:

Prefer not to say

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.
The other signatory must be either an Affiliate or Fellow of RANZCP.**

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

Aboriginal Torres Strait Islander Māori Pasifika

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If I am found in breach of the College code of conduct or code of ethics, my Affiliate status may be withdrawn without reimbursement of fees.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

The Royal Australian and New Zealand College of Psychiatrists, Box 10669; Wellington 6143; New Zealand
Telephone: +64 4472 7247 Email: nzoffice@ranzcp.org