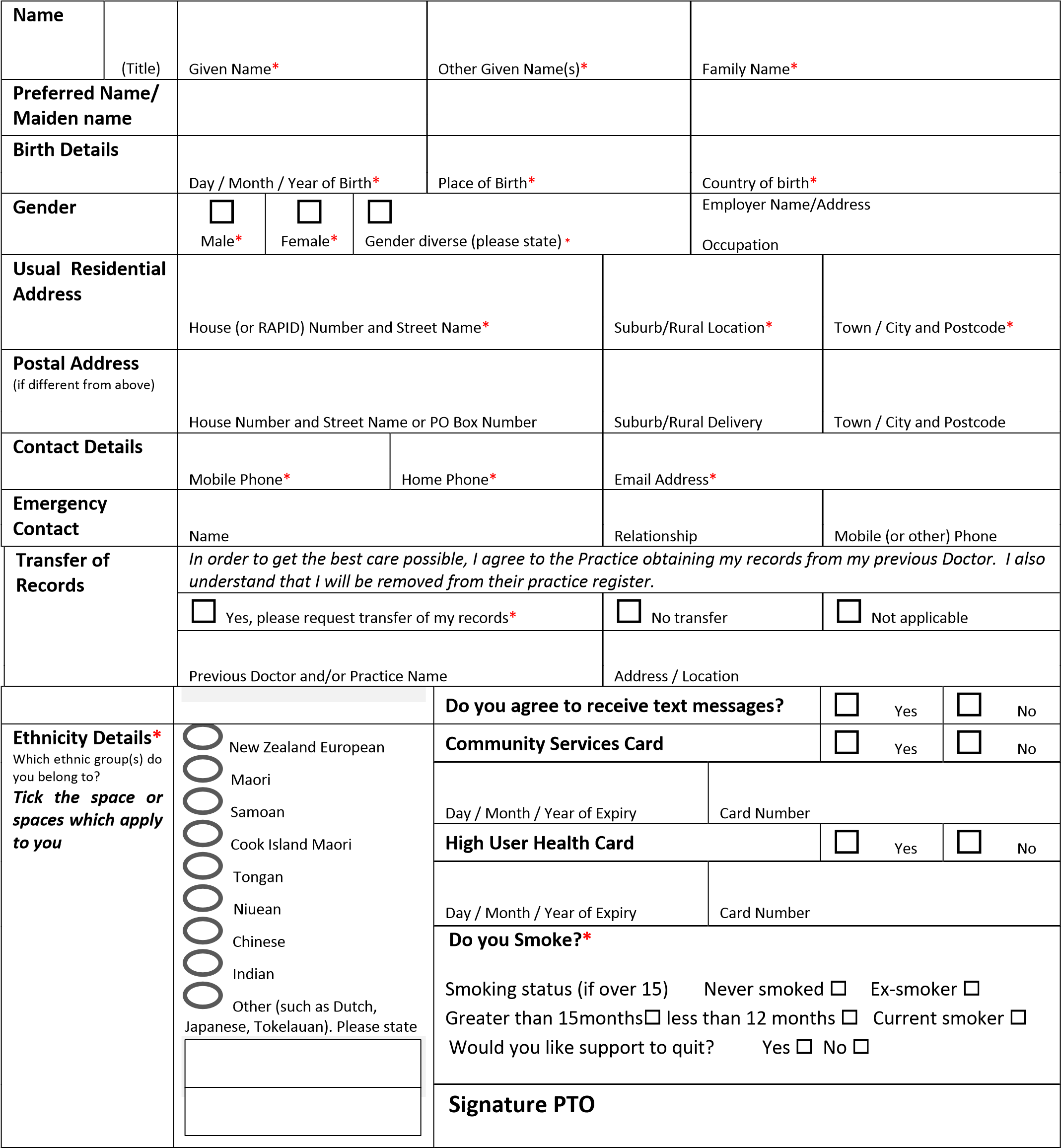
|  |  |  |
| --- | --- | --- |
|  | **PATIENT**  **ENROLMENT FORM** | PO Box 30, Waitara  **P**: 06 754 8119 **F**: 06 754 8461  **E:practice@waitarahealth.co.nz** |

|  |  |
| --- | --- |
| **Provider: GP2GP*:* EDI: waitmcwa**  **Dr C Katzen NZMC:** **28579 Dr N Reid NZMC: 61931 Dr R Shonowo NZMC: 63047**  **Dr B Wood NZMC: 20167** | NHI *(Office use only)* |



Primary Health Services Provider Enrolment Form Last Updated : 10 March 2020

**My declaration of entitlement and eligibility**

|  |  |
| --- | --- |
| **I am entitled to enrol** because I am residing permanently in New Zealand.  *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 am eligible to enrol** because:

|  |  |  |
| --- | --- | --- |
| a | **I am a New Zealand citizen** *(If yes, tick box and proceed to* ***I confirm that, if requested, I can provide proof of my eligibility*** *below****)*** |  |

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) |  |
| 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 |  |
| 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) |  |
| e | I am an interim visa holder who was eligible immediately before my interim visa started |  |
| 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 |  |
| 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 **OR** in the control of the Chief Executive of the Ministry of Social Development |  |
| 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) |  |
| i | I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme |  |
| 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 |  |

|  |  |  |
| --- | --- | --- |
| **I confirm** that, if requested, I can provide proof of my eligibility |  |  Evidence sighted (*Office use only*) |

**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 this practice, I will be included in the enrolled population with **Midlands Regional Health Network Charitable Trust**, the Primary Health Organisation (PHO) this practice belongs to, 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.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Signatory Details** |  |  |  |  |
|  | Signature\* | Day / Month / Year\* | Self-Signing | Authority |

***An authority has the legal right to sign for another person if for some reason they are unable to consent on their own behalf.***

|  |  |  |  |
| --- | --- | --- | --- |
| **Authority Details**  *(where signatory is not the enrolling*  *person)* | Full Name | Relationship | Contact Phone |
| Basis of authority (e.g. parent of a child under 16 years of age) | |  |