MDANZ Membership Application Form

Muscular Dystrophy New Zealand

TYPE OF MEMBERSHIP REQUESTED (please tick one selection) see end of page for definitions

☐ **General Member** ☐ **Young/Rangatahi Member** ☐ **Child/Nga Taitamariki** ☐ **Friend of Assn**

YOUR DETAILS **

☐ I have a neuromuscular condition (please provide your NHI# here_____

☐ I am the parent, caregiver, guardian or relative of a person with a neuromuscular condition.

☐ I am a healthcare or other support professional. My field is _____

☐ I do not have a neuromuscular condition nor any affected family members

Name: _____

Title: Mr/Mrs/Ms/Miss Gender: M/F Date of Birth: ___/___/_____

Physical address: _____

Postal address (if different): _____

Home phone: _____ Work Phone: _____

Mobile: _____ ☐ Please send me info via email

Email**:** _____

Emergency Contact Name**:** _____ Contact number**:** _____

Ethnicity (circle all that apply): NZ European/Pakeha NZ Maori (Iwi_____) Samoan Fijian Chinese Indian Tongan Japanese African Australian Cook Island Maori Other:_____

MEMBERSHIP DEFINITIONS

General Member (25 years of age and over with voting rights)

Young /Rangatahi Member (Aged between 16 and 24 years inclusive with the additional right to vote for a young representative on the National Council)

Child / Nga Taitamariki (Under 16 years of age, with no voting rights)

Friend of the Association (Interested in receiving information with no voting rights)

******Parents should fill out one form for them and another form for their child with a neuromuscular condition. We need to create different records for child and adult members due to our membership categories in our governing constitution.

DETAILS OF NEUROMUSCULAR DIAGNOSIS This is the person with the condition's details

(Do not complete this section again if these details are the same as above)

Name (of person with the condition):_____

Gender: M / F Date of birth: ____/____/_____ NHI #:_____

Physical Address(if different from above):_____

Postal Address (if different from above):_____

Contact Ph (if different from above):_____

Email (if different from above):_____

Relationship (e.g. I am this person's mother/uncle etc.):_____

CONDITION DETAILS Please specify or circle the correct option

Condition: _____ or UNKNOWN

Date of Diagnosis: _____/_____/_____ or NOT FORMALLY DIAGNOSED

Current Neurologist: _____

Current GP: _____ GP Ph: _____

GP Address:_____

☐ Yes, please send this GP information about my condition/neuromuscular conditions

If you have other family members with a neuromuscular condition please complete below

Name: _____Relationship (e.g. I am this persons mother etc.) _____

Address: _____

How did you hear about the MDA? Friend GP Neurologist Paediatrician Genetics Dept.

Website Family Other (Please specify) _____

The information I have provided is accurate. I understand that this and other information provided to the Muscular Dystrophy Association of NZ will be kept confidentially in accordance with the Privacy Act 1993 and the Health and Information Privacy Code 1994.

Name: _____

Signature: _____ Date: _____

OFFICE USE ONLY

☐ Branch/NO sent details ☐ Support Network signed ☐ Health Info Release Form signed

☐ Vega updated ☐ Membership pack sent ☐ GP pack sent

Muscular Dystrophy New Zealand

MDANZ Support Network

The Muscular Dystrophy Association of New Zealand (MDANZ) Support Networks consist of people with similar circumstances or challenges who come together to share their experiences and provide each other with emotional and moral support as well as practical advice and information. By bringing together people with common experiences and concerns, support networks can provide an invaluable addition to medical care.

The Muscular Dystrophy Association of New Zealand Support Network has over 600 members throughout New Zealand who are willing to be in touch with others. If you would like to communicate with or meet other people through the MDANZ please tell us what contact details you grant the MDANZ to share with other members of the Muscular Dystrophy Association of New Zealand. Please indicate by circling below which details you would like to share.

Home Telephone number	Y / N
Mobile Phone Number	Y / N
Email Address	Y / N

Please note: To facilitate a good match between you and the other Support Network Members we may need to share you or your child's condition, your membership type, your branch and/or the town/city you live in. By signing this form you are consenting for the MDA to do this.

If you have any queries or would like the information on starting up a support group please contact us on (09) 815 0247 or (0800) 800 337 or info@mda.org.nz

I, _____ grant permission for the Muscular Dystrophy Association of New Zealand to share my name and contact details as specified and other information as listed above, with other members of the Muscular Dystrophy Association of New Zealand Support Network. I understand that my details will be kept confidentially in accordance with the Privacy Act 1993.

SIGNATURE: _____

DATE: _____/_____/_____

Muscular Dystrophy New Zealand

Authorisation to Collect and Disclose Information

Under New Zealand law*, information about your health should always be treated carefully by health and community agencies. Therefore, we need your permission to collect or disclose information about you (or your child/family member).

The information you share with the Muscular Dystrophy Association of New Zealand (MDANZ) is voluntary. Any information collected will be stored in an electronic system which is password protected or in a locked filing cabinet. Your information will only be accessed by *relevant* MDANZ staff, who have all signed confidentiality agreements.

By signing this form, you agree to us sharing *relevant* information about you (or your child/family member) with health professionals, community or government agencies, education providers or disability support agencies. This information will only relate to the agreed goals or outcomes that we have discussed with you.

You have the right to ask for copies of information we hold about you and to ask for any inaccurate information to be corrected.

I _____ agree to information about me/my child/my family member being collected and disclosed by MDANZ.
I understand that disclosure of information will only be relevant to my healthcare and wellbeing.
I understand that information will be stored in accordance with the Health Information Privacy Code 1994.
I understand I can request copies of information from MDANZ and ask for inaccurate information to be corrected.

Signed: _____ Dated: _____

If applicable: I _____ also agree to information about me/my child being shared with the following members of my family.

Name: _____ Relationship: _____

Contact Details (where relevant): _____

**Privacy Act 1993 and Health Information Privacy Code 1994*