

# MDANZ Membership Application Form



## Personal Details

*(please complete one form per member)*

**Title:** Mr / Mrs / Ms / Miss

**Gender:** M / F / Non-binary / Do not wish to disclose

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Ethnicity:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Physical Address:** \_\_\_\_\_

**Postal Address** (if different): \_\_\_\_\_

**Preferred Contact Number:** \_\_\_\_\_ **Other Number:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Emergency Contact Name:** \_\_\_\_\_ **Number:** \_\_\_\_\_

## Neuromuscular Condition Details

*(Please complete this section if you have a neuromuscular condition)*

**Condition:** \_\_\_\_\_ or UNKNOWN

**NHI Number:** \_\_\_\_\_

**Date of Diagnosis:** \_\_\_\_/\_\_\_\_/\_\_\_\_ or NOT FORMALLY DIAGNOSED

**Current Neurologist:** \_\_\_\_\_

**Current GP:** \_\_\_\_\_ **GP Phone:** \_\_\_\_\_

**GP Address:** \_\_\_\_\_

Yes, please send my GP information about my condition/neuromuscular condition

Note: If you are the parent/guardian/relative of an existing or new member with a condition, please list their name and condition so we can link your membership accounts:

**Name:** \_\_\_\_\_ **Condition:** \_\_\_\_\_

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	Authorised by: CE	Next review date: 13-02-2023

## How did you hear about MDANZ?

Friend    GP    Neurologist    Paediatrician    Genetics Department

Website    Family    Other (Please specify) \_\_\_\_\_

*Disclosure: 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 2020 and the Health and Information Privacy Code 2020. I understand my information may be accessed by people in the services of MDANZ which includes, staff, council / committee members & volunteers.*

**Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### OFFICE USE ONLY

#### **Membership Types**

MDANZ will assign you a membership type and membership number when processing your membership application form. Your membership type & number will be noted on your welcome letter.

**Child /Tamariki Members** shall consist of anyone under the age of sixteen living with a Condition

**Young/Rangatahi Members** shall consist of anyone between the ages of sixteen and twenty-five years who is living with, or is a carrier of, a Condition

**Individual/Takitahi Members** shall consist of anyone over the age of twenty-five years who is living with, or is a carrier of, a Condition

**Family/Whānau Members** shall be one of the following:

A parent or guardian of a Child/Tamariki, Young/Rangatahi or Individual/Takitahi Member

An immediate sibling of a Child/Tamariki, Young/Rangatahi or Individual/Takitahi Member

A husband/wife/spouse/partner of a Young/Rangatahi or Individual/Takitahi Member.

**Life Member/Ringa Tōhau Nui** is a Member of a Branch who is honoured for meritorious services to the Association

**Friend of the Association/Hoa Tāpui** shall consist of any person, including any individual, health professional, incorporated or unincorporated body, who wishes to be associated with and receive information from a Branch or the Association.

Membership #: \_\_\_\_\_

Membership Type: \_\_\_\_\_

Branch/NO sent details

Support Network signed

Health Info Release Form signed

Vega updated

Membership pack sent

GP pack sent

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## Authorisation to Disclose Information

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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 people in the services of MDANZ who are MDANZ staff, committee / council members and volunteers 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 2020.  
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:** \_\_\_\_\_

\*Privacy Act 2020 and Health Information Privacy Code 2020.

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