Membership Application APGANZ Inc.

Applicant Information

Name:		
Date of birth:	Email:	Phone:
Postal address:		

Employment Information

Current employer:		
Position/Profession:		
Referee (FOR identification validation – Please Nominate a current member or Health professional who knows you)		
Name:	Email Address (if known)	Phone: (If known)

Signature

I authorise the verification of the information provided on this form	
Signature of applicant:	Application Date:
Date of acceptance:	

Membership fees are $35.00 and payable in May of each year. Please make any payments directly to our account, details below:
Bank: Kiwi Bank
Account name: Abortion Providers Group AOTEAROA New Zealand Incorporated
Account number: 38 9016 0847880 00
Please complete the form, sign & return by:
email: admin@apganz.org.nz