Retina NZ Inc.
PO Box 4567,
Manawatu Mail Centre
Palmerston North 4442
0800 569 849
admin@retina.org.nz

Membership Application Form

NAME:____
(Mr Mrs Miss Ms Dr) (First Name) (Surname)

ADDRESS:____

_______________________________ POSTCODE: ___________

PHONE: Home___________ Mobile___________ Work___________

EMAIL: ____

YEAR OF BIRTH: _____________ (For statistical purposes)

OCCUPATION ____

DIAGNOSED EYE CONDITION ________________________________

DATABASE INFORMATION – PRIVACY STATEMENT

1. The Retina NZ Membership Database includes information on the eye conditions that our members have. The information you provide on this form will help us with the services we provide and will help guide future research projects.
2. While we require the contact information of our members, we respect your right to privacy and your right to withhold or withdraw your medical information at any time, in accordance with our privacy policy.
3. The information you provide in this form will be stored in a secure database and will not be shared with external stakeholders without your consent. Retina NZ management, staff and volunteers may access your information to enable them to do their work.
4. You may request a copy of our privacy policy at any time by contacting our Administration Officer.

I agree to allow Retina NZ to use my information, in accordance with its personal information privacy policy.

SIGNED ___________________________ DATED ____________

MEMBERSHIP SUBSCRIPTION

Waged .... $ 20.00
Unwaged / Retired .... $ 10.00 (50% discount applied)
Donation Retina NZ Research .... $______
Donation Retina NZ Members' Services ...... $______
TOTAL PAYMENT $______

All donations over $5.00 are tax deductible (a receipt will be issued).
There are three ways to pay your annual subscription. Please select one.

By telephone banking or online bank transfer. The bank account number for payments to go into is: 12-3013-0845604-00. Please put your name and/or reference number in the reference box, so we can easily identify your payment.

Go into an ASB branch with this form and pay your deposit into the account number above. Remember to put your name and/or reference number in the reference box, so we can easily identify your payment.

Send us a cheque with your completed application form. (When paid, this form becomes a Tax Invoice –GST No. 53-686-885)

Which format would you like to receive your Newsletter?
(please select one)

EMAIL PRINT AUDIO-CD
EMAIL & PRINT EMAIL & AUDIO-CD

Are you a Member of the Blind Foundation? YES / NO

If you are not a person with a diagnosed eye condition, please tick in the boxes below left side of the page tf any of this information
applies to you.

I am a parent of a child/young adult with a retinal condition
(state what) ____

I am the partner / sibling / friend of someone with a retinal condition
(state what____

I am an Ophthalmologist

I am an Optometrist

I am a Scientist

I am a Healthcare Professional or Blind Foundation staff.

I have a Professional Interest in Low Vision.