Kawerau Medical Centre

Te Heke Mai o Te Hauora
The Future of Health Care

26 Islington St, Kawerau 3127, PO Box 35, Kawerau 3169, **Ph:** 07 323 6249 **Fax:** 07 323 6349
Email: KMCAdmin@ngaituhoe.iwi.nz

ALL MANDATORY FIELDS (*) ARE REQUIRED TO BE COMPLETED BEFORE ENROLMENT CAN BE PROCESSED

Enrolment Form

*Surname:			*First name:		
*Preferred Name:			Middle Name:		
*Date of Birth:	/ /	*Country of Birth:		*Place of Birth	
Gender: (leave blank if do not wish to say)	◯ Male ◯ Other ◯ Female	*Phone Number:		Title:	
*Residential Address:			NHI:_____		
*Ethnicities: (can select all that apply)	◯ NZ European ◯ Maori ◯ Samoan ◯ Cook Island Maori ◯ Niuean ◯ Tongan ◯ Chinese ◯ Indian ◯ Other (such as Dutch, Japanese, Tokelauan) Please state below:				
Employment Details:	Employer		Occupation:		
Do you hold a current	◯ Community Services Card Y/N ◯ High User Health Card Y/N (please tick or circle)				
Client Number (if yes)	_ _ _/_ _ _ /_ _ _		Email:		

Next of Kin or Emergency Contact Details

*Emergency Contact Title:		*First Name:	
*Surname:		Relationship:	
*Phone Number:		Address:	

Transfer of Medical Records from Current General Practice

Transfer of Medical Records	In order to get the best care possible, I agree to the Kawerau Medical Practice obtaining my records from my previous Doctor. I also understand that I will be removed from their practice register.	
*Current Medical:		transfer my/our records ☐ I agree ☐ do not agree to

We prefer records to be transferred via GP2GP or EDI if possible:

GP2GP: Dr Emily McNicholas NZMC#: 40547 EDI: kaw26med POST: PO Box 35, Kawerau 3169

Would you like to take part in the National Health Care Experience Survey? Links will be sent via email: YES / NO

Declaration of entitlement & eligibility

. **I am entitled to enroll** because I am residing permanently in New Zealand, as I intend to be resident in New Zealand for at least 183 days in the next 12 months.

. **I confirm that**, if requested, I can provide proof of my eligibility and I will present proof of my eligibility to the practice (enrolment is pending until proof is presented at the practice)

. **I am a New Zealand citizen**

If you are **not a New Zealand citizen** please circle which eligibility criteria (a-i) applies to you:

a) I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010); or

b) 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; or

c) 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); or

d) I am an interim visa holder who was eligible immediately before my interim visa started; or

e) 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; or

f) I am under 18 years and in the care and control of a parent/legal guardian/adopting parent who meets one of the criterion in clauses a-f above; OR in the control of the Chief Executive of the Ministry of Social Development;

g) 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); or

h) I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme; or

i) I am a Commonwealth Scholarship holder studying in NZ and receiving funding from a New Zealand university under the Commonwealth Scholarship and Fellowship Fund.

My agreement to the enrolment process

. **I understand** that by enrolling with Kawerau Medical Centre I will be included in the enrolled population of this practice's Primary Health Organisation (PHO), and my name, address and other identification details will be included on the Practice, PHO and National Enrolment Service Registers.

. **I agree,** 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 understand** that if I visit another health care provider where I am not enrolled, I may be charged a higher fee.

. **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. The survey provides important information that is used to improve health services.

. **I agree** to inform Kawerau Medical Centre of any changes in my contact details and entitlement and/or eligibility to be enrolled

. **I intend** to use Kawerau Medical Centre as my regular and on-going provider of general practice / GP / health care services.

Proof of eligibility provided	Passport / Visa	NZ Birth Certificate	NZ Driver's License
***Authorised Signature:** (An authorised Signatory has the legal right to sign for another person if for some reason they are unable to consent on their own behalf or they are the parent or legal Caregiver for a person less than 16 years of age.)			***Date:**
Full name of Authority:		**Phone:**	
Address:		**Relationship:**	