Kawerau Medical Centre

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ENROLMENT FORM

Please **complete** the **Ethnicity & Enrolment Eligibility** questions, **amend any incorrect or missing information** on this form, then **Sign and Date the form** to **validate** this enrolment - thank you.

NHI:

SURNAME:

FIRST NAME(S):

MIDDLE NAME(S):

DATE OF BIRTH:

COUNTRY OF BIRTH:
PLACE OF BIRTH:

GENDER (*For gender diverse please state as Other*):

RESIDENTIAL ADDRESS:

ETHNICITY:
Which ethnic group do you belong to?
Mark the space or spaces that apply to you.

- ☐ New Zealand European
- ☐ Maori
- ☐ Samoan
- ☐ Cook Island Maori
- ☐ Niuean
- ☐ Tongan
- ☐ Chinese
- ☐ Indian
- ☐ Other (*such as DUTCH, JAPANESE, TOKELAUAN).* Please state:

  _____

  _____

My declaration of entitlement and eligibility

☐ **I am entitled to enrol** because I am permanently residing in New Zealand.
The definition of residing permanently in NZ is that you intend to be resident in New Zealand for at least 183 days in the next 12 months.

I am eligible to enrol because:

☐ a) **I am a New Zealand citizen** *(If yes, tick box and proceed to **I confirm that, if requested, I can provide proof of my eligibility** below)*

If you are **not** a **New Zealand citizen** please tick which entitlement criteria (b-j) applies to you:

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

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☐ c) 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

☐ d) 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

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

☐ f) 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

☐ g) 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;

☐ h) 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

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

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

☐ **I confirm** that, if requested, I can provide proof of my eligibility.

Proof of eligibility provided: **Passport:** ☐ YES ☐ NO **Visa:** ☐ YES ☐ NO

My agreement to the enrolment process

NB. Parent or Caregiver to sign if you are under 16 years

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

I understand that by enrolling with Kawerau Medical Centre I will be included in the enrolled population of Eastern Bay Primary Health Alliance, and my name address and other identification details will be included on the Practice, PHO and National Enrolment Service Registers.

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

I have been given information about the benefits and implications of enrolment and the services this practice and PHO provides along with the PHOs name and contact details.

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. I can decline the survey or opt out of the survey by informing the Practice. The survey provides important information that is used to improve health services.

I agree to inform the practice of any changes in my contact details and entitlement and/or eligibility to be enrolled.

Signature/Authorised Signature: _____ **Date:** _____

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.

Full Name of Authority: _____ **Relationship:** _____

Contact Phone: _____ **Address:** _____