Kawerau Medical Centre
Te Heke Mai o te Hauora
The Future of Health Care

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ENROLMENT FORM / REQUEST FOR TRANSFER FORM

As an enrolled whānau at the Kawerau Medical Centre, this allows you to access our services

Family Name	Given Name	Gender	Date of Birth	NHI (Office Use only)
		M / F	/ /	

Preferred Name:		Place of Birth:
Contact Phone Details: Mobile: ( )	Day: ( )	Night: ( )
Email:	Street Address:	
Suburb/Town:		Postcode:
Postal Address (if different from above):		

Primary Ethnicity

☐ NZ Māori	☐ Samoan	☐ Chinese
☐ NZ European/Pākeha	☐ Niuean	☐ Indian
☐ European not defined	☐ Cook Island Māori	☐ Dutch
☐ Tongan	☐ Other Pacific Island	☐ Other

Primary - Emergency Contact / Next of Kin

Name	Relationship	Phone Number	Other contact details

I am also enrolling my dependants (Each person 16 years and over is to sign their own form unless signing authority provided)

Family Name	Given Names	DOB	Gender	NHI

Dependant - Emergency Contact / Next of Kin

Name	Relationship	Phone Number	Other contact details

Ethnicity of Dependant

Dependant 1	Dependant 2
Dependant 3	Dependant 4
If you or your dependants are of NZ Māori descent, what Iwi and Hapū do you/they belong to?	
Iwi	Hapū

Are you a smoker? ☐ Yes ☐ No Would you like help to quit? ☐ Yes ☐ No

Residential Status

Are you a New Zealand Resident?	☐ YES	☐ NO	☐ Proof Obtained
If NO do you have a work permit?	☐ YES	☐ NO	☐ Proof Obtained

Training Participation

Kawerau Medical Centre is a training facility for Doctors and Nurses. Your contribution/participation is greatly appreciated.
If you do not wish to be seen by a trainee, please let us know.

It is your right to decline / withdraw at any time from contributing / participating in these programs.

My previous Clinic / Doctors Name:	Contact Details if known:

I agree to the enrolment process and I authorise Kawerau Medical Centre to obtain my previous medical records.

I choose to enrol with this practice as my regular and ongoing provider of general practice/GP/First Level primary health care services.

I understand that I will no longer be registered with my previous Doctor.

I understand that while this practice is currently in membership of the Eastern Bay Primary Health Alliance (PHO), it is wholly owned by the Tūhoe Iwi in furtherance of it developing a Tūhoe Health System.

I agree to the Practice obtaining my records from my previous Doctor. I also understand that I will be removed from their practice register.

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

I have received and I agree with the Health Information Privacy Statement.

I agree to inform the practice of any changes in my eligibility.

Signature:..... Date:.....

Parent/Caregiver/Guardian MUST sign if patient is under 16 years old:

Signature:..... Relationship: ..... Date:.....

Enrolment into Kawerau Medical Centre

I intend to use the above named **Kawerau Medical Centre** as my regular and ongoing provider of general practice / GP / First Level Primary Health Care Service. Kawerau Medical Centre may need to send and/or discuss your health information with you and/or other health care professionals to seek assistance to ensure that we provide you with the best quality care possible.

I am eligible to enrol because I live in New Zealand and meet one of the following criteria:

a I am a New Zealand citizen **OR**

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

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 criterion in clauses a – f above **OR**

h I am 18 or 19 years old and can demonstrate that, on the 15 April 2011, I was the dependant of an eligible work permit holder **OR**

i 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**

j I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme **OR**

k 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. Initial Here:.....