NEW ZEALAND INSTITUTE OF MEDICAL RADIATION TECHNOLOGY INC

MEMBERSHIP APPLICATION

(ALL SECTIONS MUST BE COMPLETED)

Mr/Mrs/Ms/Miss/No Title ______________________________ ______________________
(Please circle) (First names) (Surname)

Postal address for correspondence ____
____

Email address – if applicable (eg for contact) ___________________________________

FORMER MEMBER Yes/No SURNAME AS FORMER MEMBER _____________ Year ____

Working Modality: Medical Imaging Radiation Therapy
(Please circle)
You may also wish to nominate a specialty: ___________________________

I HEREBY MAKE APPLICATION FOR ADMISSION TO THE NEW ZEALAND INSTITUTE OF MEDICAL RADIATION TECHNOLOGY INC.

Medical Radiation Technologist Board Registration Number: __________________
(**must be completed if applicable**)

WE, THE UNDERSIGNED, BEING FULL FINANCIAL MEMBERS OF THE NZIMRT, PROPOSE THE ABOVE APPLICANT FOR MEMBERSHIP TO THE NZIMRT.

PROPOSER: ___________________________ DATE: _________ MEMBERSHIP No: _______
SECONDER: ___________________________ DATE: _________ MEMBERSHIP No: _______

ANNUAL MEMBERSHIP FEES (For the year beginning 1st April)

Full Subscription: Ordinary { } Fellow { } Trade Representative { }	$ 200.00
Dual membership Please apply to office for fee.	
Part Time (earns less than $18,000 p.a)	$ 100.00
Associate Subscription: Darkroom Technician { } Affiliate { } Parental { }	$ 72.00
Student	$ 31.00

If you are joining partway through the financial year, please contact the General Secretary, at the address below for the pro rata subscription rate. Ph 09 379 3059 Fax 09 379 3029 E.mail nzimrt@nzimrt.co.nz
Shadows Journal-only subscription rate is available to those who wish to remain current with NZIMRT activities and/or technical changes in the profession. Please contact the General Secretary for these subscription details.
FULL PAYMENT CREDIT CARD DETAILS or AUTHORITY TO ACCEPT DIRECT DEBIT OR AUTOMATIC PAYMENT must be forwarded with this application.

Payment, please circle one Visa Mastercard Cheque/BankDraft

Credit Card No [| | |] [| | |] [| | |] [| | |]

Print Name shown on Credit Card ___________________________________ Expiry Date ____________________

Signature: ____________________________ Date: _________________________

PLEASE RETURN THIS FORM, DIRECT DEBIT/AUTOMATIC PAYMENT ADVICE AND SUBSCRIPTION FEE TO: GENERAL SECRETARY, NZIMRT, PO BOX 25 668, ST HELIERS, AUCKLAND

OFFICE USE ONLY
Membership Number: _________________________ Membership Code: ________ Date: ________