MORRINSVILLE MEDICAL CENTRE
DEPENDENT ENROLMENT FORM

Please complete the details below for all dependents that you wish to enrol in this practice and you are legally entitled to sign on their behalf.

Dependent 1:		**NHI: (office Use only)**
Family Name:*	**First Name/s:***	**Title:**
Preferred Name:	**Date of Birth:*** / /	**Gender:*** Male / Female *(Please Circle)*
Unit/House No:	**Street*** **Suburb***	**Town/City***
Next of Kin:* **First name** **Last Name**	**Relationship to dependent:***	**Ethnicity codes: (refer Below)*** **Country of Birth***

Dependent 2:		**NHI: (office Use only)**
Family Name:*	**First Name/s:***	**Title:**
Preferred Name:	**Date of Birth:*** / /	**Gender:*** Male / Female *(Please Circle)*
Unit/House No:	**Street*** **Suburb***	**Town/City***
Next of Kin:* **First name** **Last Name**	**Relationship to dependent:***	**Ethnicity codes: (refer Below)*** **Country of Birth***

Dependent 3:		**NHI: (office Use only)**
Family Name:*	**First Name/s:***	**Title:**
Preferred Name:	**Date of Birth:*** / /	**Gender:*** Male / Female *(Please Circle)*
Unit/House No:	**Street*** **Suburb***	**Town/City***
Next of Kin:* **First name** **Last Name**	**Relationship to dependent:***	**Ethnicity codes: (refer Below)*** **Country of Birth***

Smoking status *is an important factor influencing health please tick the space that applies to those aged 15 and over*

Name		Tick		Tick		Tick
	I have never smoked		In the past I have smoked daily for more than a year but no longer smoke		I am currently a smoker	
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You may select up to three ethnicity codes for each dependent to enter in the ethnicity boxes above.

Morrinsville Medial Centre
17-19 Canada Street
P O Box 86
Ph: 07 8895126
Fax: 07 889 5123
Email: postmaster@mormc.co.nz

21 *NZ Māori*	**11** *NZ European/Pākehā*	**12** *Other European*	**10** *Other European not further defined*
32 *Cook Island Māori*	**31** *Samoan*	**33** *Tongan*	**34** *Niuean*
35 *Tokelauan*	**36** *Fijian*	**37** *Other Pacific*	**37** *Other (Pacific Island not further defined)*
42 *Chinese*	**41** *South East Asian*	**44** *Other Asian*	**40** *Asian not further defined*
43 *Indian*	**51** *Middle Eastern*	**53** *African*	**52** *Latin American/Hispanic*
99 *Not Stated*	**98** *Declined*	**54** *Other (please state):*	

I AM ELIGIBLE TO ENROL IN MIDLANDS REGIONAL HEALTH NETWORK CHARITABLE TRUST

I intend to use Morrinsville Medical Centre as my regular and ongoing provider of general practice / GP / First Level primary health care services.

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.

MY AGREEMENT TO THE ENROLMENT PROCESS

- **I choose to enrol with this practice as my regular and ongoing provider of primary health care services.**
- **I understand** that by enrolling with this practice I will be enrolled with Midlands Regional Health Network Charitable Trust that this practice belongs to, and my name, address and other identification details will be included on both the Practice and the Midlands Regional Health Network Charitable Trust Enrolment Register.
- **I have been given information** about the benefits and implications of enrolment with Midlands Regional Health Network Charitable Trust, and their contact details (Enrolment Information for Patients).
- **I understand** that if I visit another provider where I am not enrolled I may be charged a higher fee.
- **I have read and I agree** with the **Health Information Privacy Statement**.
- **I agree** to inform the practice of any changes in my eligibility.

An authority is the legal right to sign for another person if for some reason they are unable to consent on their own behalf.

Signature*

Signed by AUTHORITY

Full Name of Authority	Contact Phone Number
Address	
Signature of Authority Relationship	/ / Day Month Year