



# ACMA Membership

**Auckland Chinese Medical Association Inc.**

PO BOX 128012, Remuera, Auckland. N.Z.

Name:

\_\_\_\_\_   
 Last name

\_\_\_\_\_   
 First names

\_\_\_\_\_   
 Chinese Characters

Gender: Male  Female

Country of birth: \_\_\_\_\_

Date of birth \_\_\_/\_\_\_/\_\_\_

Doctors please supply NZMC Reg No: \_\_\_\_\_

## CONTACT DETAILS

Home address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone:

Fax:

\_\_\_\_\_  
\_\_\_\_\_

Business address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone:

Fax:

\_\_\_\_\_  
\_\_\_\_\_

Email: (please PRINT)

\_\_\_\_\_

Preferred method of contact: (please tick)

Email  (Recommended)

Fax  Home  OR Office

Mail  (Mail Surcharge \$10) Home  OR Office

I do/do not want my business details on a public list

I am a: (please tick)

House surgeon

Registrar please specify \_\_\_\_\_

GP special services offered \_\_\_\_\_

I wish to receive RNZCGP CME points

Specialist please specify \_\_\_\_\_

Languages /dialects spoken \_\_\_\_\_

Annual membership fee: FULL MEMBER (\$100)

"OUT OF TOWN" (\$50)

MAIL SURCHARGE (\$20)

Please return form and payment to ACMA Membership, PO BOX 128012, Remuera, Auckland and make cheque payable to AUCKLAND CHINESE MEDICAL ASSOCIATION. Thank you.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Please tick if a receipt is required