



ACMA Membership

Auckland Chinese Medical Association Inc.

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

Name: _____
Last name *First names*

Chinese Characters

Gender: Male Female **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 \$20) 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 _____