

## Application for Membership with The Association of Dispensing Opticians of New Zealand Inc

First names: \_\_\_\_\_ Family name: \_\_\_\_\_

### PLEASE INDICATE THE TYPE OF MEMBERSHIP THAT YOU ARE APPLYING FOR



	<b>FULL</b>	Practicing Registered NZ Dispensing Optician
	<b>STUDENT</b>	Active and current member of OTEN with OptiBlocks
	<b>ASSOCIATE</b>	Retired; Non practising – but registered; or living outside New Zealand

### CONTACT DETAILS *(Email address is required – most correspondence will be sent by email)*

Email address: \_\_\_\_\_

#### WORK CONTACT DETAILS

Name of practice: \_\_\_\_\_

Postal address of practice:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_ Post Code: \_\_\_\_\_

Physical address of practice:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_ Post Code: \_\_\_\_\_

Work phone: \_\_\_\_\_

Work fax: \_\_\_\_\_

Home Address:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_ Post Code: \_\_\_\_\_

A/hours phone: \_\_\_\_\_

Please indicate where you would like to receive mail



<b>Practice Address</b>	<b>Home Address</b>

## TO BE COMPLETED BY APPLICANT

1 Date of birth: \_\_\_\_\_

2 Brief business history with dates:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3 Are you a member of any other opticians organisation? If yes, state which:

\_\_\_\_\_

\_\_\_\_\_

4 Give details of any education, professional or technical degrees or diplomas you hold

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

5 Are you registered by the Optometrists & Dispensing Opticians Board, if yes, give approximate date of registration and APC number

\_\_\_\_\_

6 If you combine any other business with Optical Dispensing, state the nature of such business

\_\_\_\_\_

\_\_\_\_\_

### NOTES:

- All information will be treated as confidential to the Executive.
- Membership will be approved upon receipt of confirmation of registration or student status.
- An invoice will be emailed to you once your application has been processed.

*I hereby make formal application for admission to Membership of the Association of Dispensing Opticians of New Zealand Incorporated and I declare that to the best of my knowledge and belief, the statements herein are true and complete in particulars. I further declare and undertake that, if elected a member of the Association of Dispensing Opticians of New Zealand Inc, I will observe and abide by all its Rules and Regulations.*

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### This form should be returned to:

<b>SCAN AND EMAIL (preferred)</b> <a href="mailto:info@adonz.co.nz">info@adonz.co.nz</a>	<b>POST</b> ADONZ PO Box 137 Morrinsville 3340 New Zealand	If you have any questions please email the office: <a href="mailto:info@adonz.co.nz">info@adonz.co.nz</a> Or phone: 07 824 1044
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