

MEMBERSHIP APPLICATION

PLEASE PRINT CLEARLY

Family name: _____ First name: _____

Address: _____

Email address: _____

Phone: _____

Mobile: _____

District Health Board (DHB): _____

Hospital: _____

Specialty (if applicable): _____

NZMC Reg Number: _____

Designation: Trainee intern House officer

Senior house officer

Registrar

I hereby acknowledge by my signature that I have read and accept the authority to act below and consent to the RDA gaining information from my employer relevant to my employment in terms of the Privacy Act.

Signature: _____ Date: _____

Each member of the Association acknowledges that by payment of subscriptions to the Association:

1. He/she irrevocably authorises and appoints the Association to act as his/her employment sole and exclusive agent in all matters, dispute or issues relating to or connected with his/her employment or prospective employment, including, but not limited to, the negotiation, settlement, execution and enforcement of any individual or collective contracts, or part thereof relating to his/her employment.

2. He/she shall be bound without qualification by all or any of the terms of any individual or collective contract or contracts which cover or concern his/her employment and are negotiated by the Association and are duly ratified.

3. He/she will be bound by and shall comply with any procedure for the ratification of any settlement of negotiations relating to the terms and conditions of his/her employment to which the Association may agree pursuant to 5.51 of the Employment Relations Act 2000.

4. Such authority and appointment shall continue in force and effect unless his/her membership of the Association should terminate for any reason.

RESIDENT DOCTORS' ASSOCIATION

PAYMENT OPTIONS

Annually

by **cheque**, payable to: NZRDA

or by **internet banking** (see instructions below)

\$480.00 from 1 December to 1 December for all
Resident Medical Officers.

\$10.00 per annum for Trainee Interns.

OR

Monthly from your bank account using internet / telephone banking.

\$40.00 per month

Name of account: NZRDA,

Bank: ASB

Account number: 123016 0492242 00

Important:

To appear on *your* statement write: "RDA Subs"

To appear on *the NZRDA's* statement write your
surname plus first initials, so that we can easily identify
your payments for our records.

Please send these two forms to:

New Zealand Resident Doctors' Association

PO Box 56-431

Dominion Road,

Auckland 1446

or fax to 09 6233996

or give them directly to your RDA representative.

Alternatively you may join by emailing us at :

membership@nzrda.org.nz