



Membership application form

Membership details

Pharmacy name	
Trading name	
Street address	
Postal address	
Phone number/s	
Email address/s	
Guild website password	

List pharmacist licence holder/s (collective holders of not less than 51% of the pharmacy):

List the pharmacist and pharmacy name where an interest of 10% or more is held in another pharmacy:

Guild Rules state that all pharmacies with joint ownership must be members of the Guild for any of the pharmacies to receive our services. Please contact us to discuss membership options further.

Membership fees

☐ After being invoiced, I agree to pay membership fees by the 20th of the month following invoice date.

Payment method: ☐ Direct debit (form will be posted) ☐ Direct credit (01-0517-0002404-000)

Payment frequency: ☐ Monthly ☐ Quarterly

Declaration

I apply for full membership of the Pharmacy Guild of New Zealand (Inc) and agree to be bound by the rules of membership and consent to the privacy policy. Visit the 'Join' page at www.pgnz.org.nz to read the Guild Rules and Privacy Policy.

Signed		Date	
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Please send your completed form to membership@pgnz.org.nz.