

Retina New Zealand Inc.
P O Box 2232, Raumati Beach 5255
Tel: 0800 233 833 or 04 299 1801
Email: membership@retina.org.nz

Membership Application or Renewal Form

NAME:
(Mr/Mrs/Miss/Ms/Dr) (First name) (Surname)

ADDRESS:
.....

PHONE: Home: (0) Bus: (0)

EMAIL:

MOBILE:

AGE BRACKET: 0-16, 17-30, 31-45, 46-60, 61-75, 76+ (Circle one)

OCCUPATION: (Optional).....

MEMBERSHIP: Waged: \$20.00
Unwaged/Retired \$10.00
Donation: \$.....
Total Payment: \$.....

(Donations of \$5.00 or more are tax deductible)

I attach Cheque No..... for the sum of \$.....

made payable to **Retina New Zealand Inc** for my subscription for the year commencing 1 April 2008 / 2009 / 2010. (Circle One)

If you wish to pay your Retina NZ subscription by telephone banking or on-line bank transfer, the bank account number for payments to go into is:

12-3013-0845604-00. Please put your initials & surname in the reference column so that we can easily identify your payment.

NEW MEMBER / RENEWAL: (Circle One)

How do you want to receive your newsletter IN PRINT / ON TAPE / BY EMAIL ? (Please circle applicable format(s))

Are you a member of the Foundation of the Blind? YES / NO

SIGNED **DATE**

Retina NZ has a database showing the type of macular and retinal conditions that our members have. We ask that new members complete the Database Information Form. The information in this form will be securely stored on the data information file. It will only be released to or accessed by Society office holders to enable these persons to do their work. Organisers of local meetings will only have access to the contact details of people in their local area.

Database Information Form

Please tick in the brackets on the left hand side of the page the information that applies to you.

- () I have Retinitis Pigmentosa**
- () I have Usher syndrome**
- () I have Age-related Macular Degeneration (AMD)**
- () I have another form of Macular Degeneration (MD) other than AMD**
(State what).....
- () I have Diabetic Retinopathy**
- () I have had one or more Retinal Detachments**
- () I have another retinal condition or non retinal condition eg Glaucoma**
(State what)
- () I am a parent of a child/young adult with one of the above:**
(State what).....
- () I am the partner/sibling/close friend of someone with a retinal condition**
(State what):
- () I am an ophthalmologist or scientist**
- () I am an optometrist**
- () I am a healthcare or RNZFB professional**