City Medical Centre
Level 2/ 190 Lambton Quay, Wellington.
PH: 04 471 2161 Fax: 471 2162

Request to be Enrolled with this Practice

Title: …….. Proof of ID:……..

Family Name:…… First Name: …… **Middle Name: ……..**

Date of Birth:…… Gender: ……

Address:……

Personal Email:……

Telephone - After hours: …….. **Day:…… Mobile:……..**

I agree for communication by txt to the above mobile phone number: Yes No (please Circle)

Community Services or High User Card YES / NO

If YES- Card Number:…… Expires:……

Employment - Occupation: …… Employer:……..

Next of Kin/Emergency Contact Details: *(If appropriate please put both parents for under 16 years)*

Name: ……

Relationship:…… Contact Phone:……

What country were you born in?……

What City were you born in?……

Ethnicity - Which Ethnic group do you belong to? (*you may select more than one ethnicity***):**

11 NZ European/Pakeha	*21 NZ Maori*	*IWI:*	*12 Other European*
31 Samoan	*33 Tongan*	*34 Nieuan*	*35 Tokelauan*
36 Fijian	*37 Other Pacific*	*32 Cook Island Maori*	*42 Chinese*
41 South East Asian	*44 Other Asian*	*43 Indian*	*51 Middle Eastern*
53 African	*52 Latin American/Hispanic*		*98 Declined*

*Other (Please State)*_____

Enrolment Eligibility

I am eligible to enrol in Compass Primary Health Care Network and intend to use City Medical Centre as my regular and ongoing provider of general practice/GP/First Level primary health care services.

I am eligible and entitled to be enrolled in this PHO as I am residing in New Zealand and meet one of the following criteria:

Continued on next page:

Enrolment Eligibility Continued:

Please circle:

a) I am a New Zealand citizen **OR**

b) I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010) **OR**

c) I am an Australian citizen or Australian permanent resident AND able to show I have been in New Zealand or intend to stay in New Zealand for at least 2 consecutive years **OR**

d) I have a work visa/permit and can show that I am able to be in New Zealand for at least 2 years (work visa's start on your first day in New Zealand) (previous permits included) **OR**

e) I am an interim visa holder who was eligible immediately before my interim visa started **OR**

f) I am a refugee or protected person OR in the process of applying for, or appealing refugee or protection status, OR a victim or suspected victim of people trafficking **OR**

g) I am under 18 years and in the care and control of a parent/legal guardian/adopting parent who meets one criterion in clauses a-f above **OR**

h) I am 18 or 19 years old and can demonstrate that, on the 15 April 2011, I was the dependant of an eligible work permit holder **OR**

i) I am a NZ Aid Programme student studying in NZ and receiving Official Development Assistance funding (or their partner or child under 18 years old) **OR**

j) I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme **OR**

k) I am a Commonwealth Scholarship holder studying in NZ
and receiving funding from a New Zealand university under the Commonwealth Scholarship and Fellowship Fund.

I confirm that, if requested, I can provide proof of my eligibility.

MY AGREEMENT TO THE ENROLMENT PROCESS

- **I intend to use this PHO as my preferred provider of Primary Health Services**
- **I understand** that by enrolling with this practice I will be enrolled with **Compass Primary Health Care Network,** which is the Primary Health Organisation this practice belongs to, and my name, address and other identification details will be included on both the Practice and the **Compass Primary Health Care Network** Enrolment Register.
- **I understand** that if I visit another provider where I am not enrolled I may be charged a higher fee
- **I have read and I agree** with the **Health Information Privacy Statement**.
- **I agree** to inform the practice of any changes in my eligibility.

Signature:…… **Todays Date**: ……..

Name of Authority:_____

An authority is the legal right to sign for another person if for some reason they are unable to consent on their own behalf.

Relationship:…… Address:……

Contact Phone Number:……

A separate enrolment form is required for each patient including dependents, people 16 years or over are to complete and sign their own form

(Please return this completed form to reception with your proof of ID)