# PRACTICE STAFF DETAILS

**Clinical staff:** Please attach copies of your Annual Practising Certificate and Medical Protection Society Certificate.

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|  | | | | | | | |
| Surname: | | | | | | Mr / Mrs / Ms / Miss / Dr | |
| First name(s): | | | | | | | |
| Street address: | | | | | | | |
| Postal address: | | | | | | | |
| Date of birth: | | | | | | | |
| Contact numbers: (home) | | | | (mobile) | | | |
| Email address: | | | | | | | |
|  | | | | | | | |
| Bank name: | | | | | | | |
| Bank account #: | | | | | | | |
| IRD #: | | | | | | | |
| Are you GST registered? **Yes No** | | If yes, GST number: | | | | | |
|  | | | | | | | |
| Do you have any medical conditions or allergies that the practice should be aware of? **Yes No** | | | | | | | |
| *If yes, please list them here:* | | | | | | | |
|  | | | | | | | |
| **Contact Person** | | | | | | | |
| Name: | | | | | | | |
| Contact number: (home) | | | (mobile) | | | | |
| Relationship to you: | | | | | | | |
|  | | | | | | | |
| Signature |  | | | | Date | |  |