

**Please complete all editable sections of this form electronically and return by email to the address above**

**Please provide practice details**

Practice name	<b>Practice Membership number (Office use only)</b>  Practice Membership is designed to make the benefits of Medical Protection membership available to GP practices. To apply to join Practice Membership please complete this form, return this to <a href="mailto:nzpractice@medicalprotection.org">nzpractice@medicalprotection.org</a>
Practice address	
Postcode	
Telephone	
Fax	
Email address	

**Section 1 – Medical Protection existing member confirmation and consent for Practice Membership**

Please list and provide practice information for the current Medical Protection GP members to be included in Practice Membership and ask each to sign overleaf to confirm their details and agreement.

By signing each signatory confirms that they:

Have checked and confirm that the information regarding their practice information is correct and will promptly inform Medical Protection of any change to their personal circumstances, scope of practice or other details (including in relation to income and number of hours worked).

- Consent to their membership being transferred to Practice Membership.
- Understand that their personal Medical Protection membership will be retained but:
  - Their membership subscription renewal date will be brought in line with that of the practice and this may affect their current subscription payment schedule
  - The membership correspondence address will be changed to that of the practice and membership documentation may be shared with the practice administrator
- Authorise and agree that Medical Protection and the practice administrator may share information in respect of their membership and authorise the practice administrator to provide details of any changes to their scope of practice.
- Agree that Medical Protection may seek information from other professional defence organisations, insurance companies, employers or other third parties in respect of membership and that they may release to MPS such information.

**Personal Information and Data**

When interacting with Medical Protection, members may choose to give Medical Protection information about your criminal convictions and offences (including alleged offences), your health, race, ethnic origin, sex life, sexual orientation and trade union membership (“Special Category Data”). This happens where that information is relevant to membership or the actual or potential provision of advice, assistance or indemnity. We may also receive Special Category Data about members from others in connection with membership or advice, assistance or indemnity (e.g. from a complainant, claimant, witness, expert, court or regulator). We ask for members’ express consent to process their Special Category Data. Members may withdraw consent to such processing by contacting Medical Protection, but if they do so we will no longer be able to provide them with membership and its benefits.

To find out more about how we collect, use and handle your data including Special Category Data, please see the privacy statement on our website [medicalprotection.org](http://medicalprotection.org)

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<b>Section 1 – continued</b>	
<b>Name</b>	<b>Signature</b>
Medical Protection membership no:	No. of hours worked weekly:
<b>Name</b>	<b>Signature</b>
Medical Protection membership no:	No. of hours worked weekly:
<b>Name</b>	<b>Signature</b>
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<b>Name</b>	<b>Signature</b>
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Medical Protection membership no:	No. of hours worked weekly:
<b>Name</b>	<b>Signature</b>
Medical Protection membership no:	No. of hours worked weekly:
<b>Name</b>	<b>Signature</b>
Medical Protection membership no:	No. of hours worked weekly:

**Section 2 – New Medical Protection members to be included in your Practice Membership**

**By signing and returning this form, you agree and confirm that:**

- i. You wish to apply for membership of MPS subject to the Memorandum and Articles of Association.
- ii. You understand that any failure to disclose full and accurate details may delay your application and/or if you are accepted into membership could result in the suspension and/or withdrawal of membership benefits and/or the cancellation and/or termination of membership.
- iii. You understand that membership is not conferred automatically and is subject to approval by MPS.
- iv. You acknowledge that any subscription payments made are subject to verification and that acceptance of a payment by MPS does not of itself confirm membership and/or entitlement to request benefits.
- v. You will inform us if your personal circumstances or scope of practice change.
- vi. We may seek information from other professional defence organisations, insurance companies, employers, and/or other third parties in respect of membership and that they may release to us such information.
- vii. For the purposes of New Zealand Law and the New Zealand Privacy Act 2020, we may obtain, process, retain and transfer your personal information as set out in the Privacy Notice on our website **medicalprotection.org**

Each individual non Medical Protection member wishing to join Medical Protection and to be included in your Practice Membership, will need to complete an individual application.

**Name**

No. of hours worked weekly: Preferred start date (DD/MM/YYYY)

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**Name**

No. of hours worked weekly: Preferred start date (DD/MM/YYYY)

The nominated Practice Membership administrator should sign and date this form on behalf of the practice

**Please note:**

- By signing this form you are confirming that the details provided on this form are correct to the best of your knowledge.
- You will still need to complete an individual Medical Protection application form for yourself, if you are not already a member.

Please ensure all who are required to sign this form and consent to Medical Protection processing their Special Category Data before returning to Medical Protection.

Title

Forename(s)

Surname

Position held in practice

Signature

Date: (DD/MM/YYYY) please note must be current date

## Medical Protection

Please return the completed form by email to [nzpractice@medicalprotection.org](mailto:nzpractice@medicalprotection.org)