IDFNZ
Immune Deficiencies Foundation of New Zealand

IDFNZ Adult/Child Patient Membership Application Form

Contact Details:

Name:		**Parents names if child MemberAQ:**
Address:		
Telephone:		
Fax:		
E-mail Address:		

Details		
Gender: **F / M**	**Date of Birth:**	**Ethnic Group:** ***(Needed for HFA statistics)***
PID Disorder: (must be specific) **When diagnosed:**	**Treatment Regime:**	

Immunologist Name: **Comments:**	**Contact details**	**Immunologist Signature: (to verify medical details on this form)**

Would you like to receive information on this disorder from IDFNZ? (Y / N)

Would you like regular contact by An IDFNZ Support person? (Y / N)

Would you be interested in IDFNZ putting you in contact with other members suffering from the same / similar disorder? (Y / N)

Would you like to receive the regular newsletter (Y / N)……By mail / by e-mail (where possible)

Tell us about yourself (family, interests, hobbies etc.)

How would you like IDFNZ to support you?

Would you be interested in participating in IDFNZ / support events? (Y / N)

Would you be interested in offering your skills / services to benefit IDFNZ? (Y / N)

(Continue on the back if you wish to add any further information)

I (*name*)……..give IDFNZ permission to release my name and details to support staff / IDFNZ Medical panel in order to enable full participation and support by the Foundation.
Date;…… signed…….

Please return the completed form to: IDFNZ Registration, PO Box 75-076, Manurewa, Auckland, NZ.

Confirmation of membership will be sent by mail. The regional co-ordinator will be in direct contact shortly after*. Note: IDFNZ requires an immunology specialist to complete section * above for applications to be accepted. IDFNZ reserves the right to updated medical information when requested to accurately maintain our records.*