



ENROLMENT CONSENT

- YES, I wish to enrol with Radius Medical Davies Corner / Rototuna / St Andrews / K’aute Family Medical Centre as my regular and on-going provider of general practice/ GP/ first level primary healthcare services**
(please circle your preferred clinic location)
- NO, I do not wish to be enrolled at this medical centre today.**

ELIGIBILITY

I am eligible to enrol **because** I live in New Zealand and **I meet one of the following criteria (please tick one of the following):**

- I am a New Zealand Citizen **OR**
- I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010) **OR**
- I am an Australian citizen or Australian permanent resident AND am able to show I have been in New Zealand or intend to stay in New Zealand for at least 2 consecutive years **OR**
- I have a work visa/permit and can show that I am able to be in New Zealand for at least 2 years (previous permits included) **OR**
- I am an interim visa holder who was eligible immediately before my interim visa started **OR**
- 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**
- I am under 18 years and in the care and control of a parent/legal guardian/adopting parent who meets one criterion in the clauses above **OR**
- I am 18 or 19 years old and can demonstrate that I am the dependent of an eligible work permit holder **OR**
- I am a NZ aid programme student studying in NZ and receiving official development assistance funding (or their parent of child under 18 years old) **OR**
- I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme **OR**
- I am a commonwealth scholarship holder studying in NZ and receiving funding from a NZ university under the commonwealth scholarship and fellowship fund.

I confirm that, if requested, I can provide proof of my eligibility YES NO

MY AGREEMENT TO THE ENROLMENT PROCESS

I understand that by enrolling with this practice I will be enrolled with the National Hauora Coalition PHO to which this practice belongs, and my name, address and other identification details will be included in the practice and PHO enrolment register.

I understand that if I visit another provider where I am not enrolled I may be charged a higher fee.

I have been given information about the benefits and implications of enrolment with the PHO, and their contact details.

I have read and I agree with the Health Information privacy statement given to me by the practice.

I agree to inform the practice of any change to my eligibility.

SIGNED:

DATE: