medical technology
ASSOCIATION OF NEW ZEALAND

2020/2021 Associate Membership Application Form

Associate membership of the Medical Technology Association of New Zealand (MTANZ) is available to persons, firms or companies who have sufficient commonality of interest with the Society Members. Associate members are invited to join MTANZ by invitation of the Executive Board.

Associate members are not entitled to vote on any question or be elected to the Executive Board.

This application form is to be completed *in full* and returned to MTANZ via email admin@mtanz.org.nz or post to P.O. Box 74116 Greenlane Central, Auckland 1546.

Company Details

Company Name:_____

Country of Ownership:_____

Trading Name:_____

Street Address:_____Post Code_____

Postal Address:_____Post Code_____

Main Phone:_____**Email** _____

Website:_____

Principal Activities

What are the principal activities of your company in New Zealand? (*please tick all that apply*)
□ Consultant   □ Technician
□ Service provider
□ Other
_____

Employees & Company Revenue

How many people does your company employ in New Zealand? **Total_____**

What is your annual company revenue? **Total $_____**

Name_____Work Position_____

Email Address _____

Name_____Work Position_____

Email Address _____

Nomination

All applications for membership of MTANZ must be nominated by a current MTANZ member.

Nominated by (company name):_____

I support the application of (company name):_____

Signature_____

Associate Membership Fees

Annual membership fees are due for payment 1 April 2020.
Membership fees can be paid in quarterly instalments.

Annual Fees for 2020/2021 are $1,020 plus GST

Accounts Email Address_____

Declaration

I (name)_____Authorised Representative of

(company name)_____

Hereby apply for Associate membership to the Medical Technology Association of New Zealand for 2020/2021. As an Associate member of MTANZ, I confirm that the company will:

   a) abide by the Rules of the Medical Technology Association of New Zealand
   b) abide by the MTANZ Code of Practice

Signature:_____ **Date:**_____

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