



CLUTHA HEALTH INC
Iwikatea Hauora Inc

Clutha Health Incorporated Application Form for Membership

APPLICANT DETAILS

Full name:

Residential address:

Postal address (if different):

Phone:

Email:

You consent to receiving notices and other communications from us by email, text and other forms of electronic communication. Any such communication may include a link to such information and may not always include a functional unsubscribe facility.

APPLICATION FOR MEMBERSHIP

1. I confirm that I wish to become a member of Clutha Health Incorporated (the **Society**), an incorporated society under the Incorporated Societies Act 1908 (the **Act**).
2. I confirm that I am qualified to be a member of the Society on the following basis (*select*):

- ☐ I am a resident of the Clutha District and am currently eligible to vote in the local body elections for the Clutha District.

OR

I am applying for membership on the following grounds (and acknowledge and accept that the Board has discretion regarding whether to accept my application on such grounds):

- ☐ My place of employment or place of business is within the Clutha District;
- ☐ I am a current employee of the Society;
- ☐ I have been nominated for membership by an association or other body, incorporated or unincorporated, operating within the Clutha District; or
- ☐ I am nominated for membership by the following 2 current members of the Society:

Member Name: _____ Member Name: _____

Signature: _____ Signature: _____



Clutha Health Incorporated Application Form for Membership (*cont.*)

3. I understand and agree that, if my application for membership is approved, my name and address will be added to the register of members of the Society and that I may resign my membership in the Society at any time.
4. I agree that I will be immediately bound by, and agree to comply with all members' obligations in, the constitution of the Society (as may be amended from time to time) (**Constitution**) and to support the Society's objectives as set out in the Constitution (a copy of which is available from the Society upon request).
5. I consent to the information provided in this form being used and held by the Society and the Board for the membership purposes and general purposes of the Society, in accordance with the Privacy Act 2020, the Act and any other relevant legal requirements of the Society.
6. I declare that to the best of my knowledge and belief the information in this form is true and correct and not misleading in any manner and that I agree to promptly notify the Society if there are any changes to any information on this form or which may affect my membership in the Society.

Signed by the Applicant

Applicant name: _____

Signature: _____

Date: _____

Note:

- Completed application form must be sent to cluthahealthinc@chf.co.nz or provided to a member of the Board for processing.
- Application form must be completed, received and accepted prior to commencement of a general meeting for the applicant to be considered a member and have any voting rights at that meeting.

Office Use Only

- ☐ Application received on: _____
- ☐ Approved by Board on: _____
- ☐ Date of first Society meeting member accepted for: _____
- ☐ Entered into Register of Members on: _____
- ☐ Notification sent to applicant on: _____

Signed by Secretary / on behalf of Board of Society: _____