NZMA
New Zealand Medical Association
Te Hauora mō ngā Iwi Katoa

Membership
Credit Card Payment Form

Please scan and email to: julie@nzma.org.nz
OR send to:
Freepost 185168
New Zealand Medical Association
PO Box 156
Wellington 6140

MEMBER'S NAME *	
MEMBERSHIP NUMBER *	
CONTACT PHONE NUMBER *	
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Credit card details: ☐ Mastercard ☐ Visa ☐ Amex

Name on card: ____ Expiry Date: _ _ / _ _

Card Number: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Signature: ____