Complete this form to apply for a digital certificate as an individual user. Email this completed form to the New Zealand Health & Disability Sector Registration Authority (NZHSRA) [registration.authority@acc.co.nz](mailto:registration.authority@acc.co.nz).

For help or questions, email [registration.authority@acc.co.nz](mailto:registration.authority@acc.co.nz) or call 0800 117 590.

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| 1. Organisation details | |
| Organisation name as registered with NZHSRA: | |
| Organisation phone: | Organisation email: |

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| 1. Applicant’s details for certificate | |
| Note that:   * A mobile phone number is needed for two-step authentication because you’ll get a text message during registration.   The email address you provide needs to be unique to you. | |
| Contact name: | Job title: |
| Work phone: | Work mobile: |
| Email address: | |
| If you want to receive the annual renewal reminder for your digital certificate to a different email address, tell us which one. | |
| Email address I would like the reminder sent to: | |

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| 1. Application access |
| Please indicate which application/s you are applying for access to. If you are unsure, email [registration.authority@acc.co.nz](mailto:registration.authority@acc.co.nz) or call 0800 117 590. You will need to apply for individual user access directly with the application owner. |
| I need access to (tick all that apply):  ACC electronic transactions (eg electronic invoicing and/or ACC45 submissions, etc)   If your organisation uses a Practice Management System (PMS) please tell us the name of   the system you use / will use:  CareConnect (For specialists and allied health providers using a portal to send referrals   to Health New Zealand in Auckland and Northland. Not applicable to GP practices).  ​ HIN (Health Intranet Network) ​  NHI (National Health Index)  ​​  ​NIR (National Immunisation Register)  ​NZCSP (NZ Cervical Smear Programme)  ​ Special Authority  ​ Other: |

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| 1. Declaration by authorised signatory | |
| This section must be completed by an authorised signatory in your organisation, as supplied in your organisation’s registration with the NZHSRA. | |
| I declare that:   * the information given in this form is true and correct, and that I authorise the NZHSRA (as the accredited Registration Authority) to verify this information. * I accept that the NZHSRA may decline any application or revoke any certificate at any time. | |
| Authorised signatory name: | |
| Authorised signatory job title: | Date: |

In the collection, use, disclosure, and storage of information, ACC will at all times comply with the obligations of the Privacy Act 2020, the Health Information Privacy Code 2020 and the Official Information Act 1982. For further details see [ACC’s privacy policy](https://www.acc.co.nz/privacy/our-privacy-framework).