HealthSecure organisation registration form

Use this form to register your Organisation for Digital Certificate issuance. Sole practitioners, counsellors etc, must complete this application form to have your business registered with NZHSRA for Digital Certificates.

If you require assistance completing this form please call NZHSRA (New Zealand Health & Disability Sector Registration Authority) on 0800 117 590. ***Please Note: All sections on this application form are mandatory.***

1. ORGANISATION DETAILS

This form was completed on: [/ /]

Organisation trading name to be registered with NZHSRA:	
Organisation legal name if different to above:	
Physical address (To where CD will be couriered to):	Post code:
Postal address (if different):	Post code:

2. APPLICATIONS

User applications from your organisation will primarily be for (Please indicate all that is required):

☐ Ministry of Health - Health Network (e.g. NHI, NIR, Special Authority etc)

☐ ACC Electronic Transactions (eg. E-billing)

☐ CareConnect

Do you have access to a CD Drive to install the Digital Certificate?

Yes No (Please indicate)

Access to the Health Network must be approved by the Ministry of Health before we are able to proceed with this application. http://www.health.govt.nz/our-work/health-network/how-join-health-network provides further information and the necessary form to assist you.

3. ORGANISATION CONTACT

Contact name:		Contact title:
Work phone:	Mobile phone:	Email:

Preferred method of contact: ☐ Work phone ☐ Mobile phone ☐ Email ☐ Post

4. ORGANISATION AUTHORISED SIGNATORIES

Please supply names of authorised signatories for your organisation. These signatories can approve certificate requests on behalf of your organisation and revoke user certificates. You will need to provide at least 2 signatories unless you are a sole practitioner.

Name:	Signature:
Name:	Signature:
Name:	Signature:
Name:	Signature:

5. ORGANISATION ACCEPTANCE

I declare that the information given in this form is true and correct, and that the NZHSRA (as the accredited Registration Authority) is authorised to verify this information.

I have approved the authorised signatories listed on this application.

I accept that the NZHSRA may decline any application or revoke any certificate at any time.

I agree that renewal certificates will be charged to the organisation at the specified renewal rate unless subsidised.

Name:	Job title:
Signature:	Date:
ACC Vendor No.(if applicable):	
By executing this agreement the signatory warrants they are duly authorised to execute this agreement on behalf of the organisation.	

6. WITNESS DECLARATION

A witness must be a member or registered practitioner of one of the following: **Member of NZ Law Society, Member of the Institute of Chartered Accountants of NZ, Justice of the Peace, Dental or Medical Council Member or a Member of the Pharmacy Council of New Zealand.**

The witness can not be an authorising signatory or the organisation acceptor as detailed on this form.

I confirm that I have identified the person, and their position, who has signed this organisation acceptance. They have signed this Organisation Registration form in my presence. The NZHSRA has my permission to confirm my witness status.

Please enter your details below:

Membership body:	
Membership reference:	
Full name:	
Phone:	Job title:
Signature:	Date:

Send the original completed registration form to:

NZHSRA
P O BOX 30823
LOWER HUTT 5040 or send to Registration.authority@acc.co.nz

New Zealand Health & Disability Sector Registration Authority
In the collection, use and storage of information the NZHSRA will at all times comply with the obligations of the Privacy Act 1993 and the Health Information Privacy Code 1994.