

APPLICATION FOR MEMBERSHIP	
COMMUNITY LAW CENTRE EMPLOYEES/JUNIOR PRACTITIONERS	
Name:	
Firm:	
Address:	
Telephone:	
Fax:	
Email:	
Website:	
Date of first practising certificate:	

AREAS OF PRACTICE

The Section fields daily enquiries from members of the public who need a Family Lawyer. The areas of practice below will display on the public area of the website. Please select the areas of law in which you currently practise:

- | | |
|---|---|
| <input type="checkbox"/> Adoption | <input type="checkbox"/> Legal Aid |
| <input type="checkbox"/> Care & Protection (CYFS) | <input type="checkbox"/> Mental Health |
| <input type="checkbox"/> Child Support | <input type="checkbox"/> Paternity |
| <input type="checkbox"/> Day-to-day Care & Contact | <input type="checkbox"/> Protection of Personal & Property Rights |
| <input type="checkbox"/> Death & Family Protection | <input type="checkbox"/> Relationship Property |
| <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Relocation |
| <input type="checkbox"/> Guardianship | <input type="checkbox"/> Spousal Maintenance |
| <input type="checkbox"/> International/Hague Convention | |

PUBLICATION

I agree to my details being published on the Family Law Section website.

PRIVACY

The Family Law Section respects your privacy. Personal information collected from this form will only be used to process your application and for purposes which are related to your Section membership.

PAYMENT FOR ASSOCIATE MEMBERSHIP IS \$100.00 (GST inclusive)

The Section has offered a discounted price for Community Law Centre employees and junior practitioners who have held a practising certificate for less than 2 years. A paid tax invoice will be sent to you after the payment is banked.

PAYMENT OPTIONS

Option 1: Cheque I enclose a cheque made payable to the "NZLS Representative Services"

Option 2: Direct credit ASB Bank: 123140-0119103-00
Reference: Your last name
Please email notification to: family@lawsociety.org.nz

Option 3: Credit card
Please charge \$100.00 to my credit card:

Type of Card: Visa Mastercard AMEX

Card Number:

Expiry Date: ____ / ____

SIGNATURE:

DATE:

PLEASE SEND TO:

Fax: 04-463 2983
Post: PO Box 5041
Lambton Quay
WELLINGTON 6145