Te Poari Tautoko I Nga Rohe Ki Te Raki

Northern DHB Support Agency Ltd

Working with District Health Boards towards excellence in health and disability support services

Application for Provision of Oral Health Services to Adolescents and Special Dental Services to Children and Adolescents Agreement & Payee Number

Please complete this form and return it to Northern DHB Support Agency Ltd, Contract Administrator PO Box 112147, Penrose, Auckland or fax to (09) 589 3901

Tick	Reason for Application (Compulsory)	
☐	**New Dental Practice**	No previous Dental Practice on this site.
☐	**Change of Ownership**	Specify name of previous owner:

Full Legal Entity Name (Compulsory): *(i.e. which is to appear on Agreement documentation)*	
Full Practice or Trading Name: *(if different from the Legal Entity Name)*	
Authorised Signatory for Agreement (***compulsory***)	

		Registration #
List of practitioners providing services under this Agreement **(compulsory)**		

Physical Address of Practice (***compulsory***)	

Postal Address *(If different from above)*	

Practice Phone Number:	
Practice Fax Number:	
Email Address:	

Start date for this Agreement: *(compulsory):*	

Name & Physical Address of other Practices to be covered under this Agreement	

Other contracts held – name of contract(s) and contract number(s)	

Practicing Certificate **PLEASE ENCLOSED A COPY OF PRACTITIONER(S) CURRENT ANNUAL PRACTISING CERTIFICATE(S).**

Direct Credit Details **PLEASE ATTACH A DEPOSIT SLIP WITH APPLICATION**

GST Registration *(Please tick the appropriate box)*

☐	Yes, I am registered for GST. My number is:								

☐	No, I am not registered for GST.

Signature: _____ Date: _____

CHECKLIST

(Please ensure that all of the attachments are enclosed with application as any missing documentation will create a delay in processing)

☐	Yes, I have enclosed a copy of the relevant Practicing Certificate. ***NB: If agreement is for Practice, please ensure that the Annual Practising Certificates of all dentists who will be working in this practice are attached.***
☐	Yes, I have attached pre-printed or bank verified Bank Deposit Slip
☐	Yes, I have attached a Copy of Certificate of Company Registration (if applicant is a Limited Liability Company)
☐	Yes, I have attached a Copy of Partnership/Trust Deed (if applicant is a Partnership or Trust)

Notes:

1. Contact the Northern DHB Support Agency if you have a query about primary care agreements and notices by phoning the Contracts Administrator in the first instance on (09) 589 3922 or email contractadmin@nra.health.nz
2. Sector Services are responsible for all payments.
3. All inquiries about payments should be directed to Sector Services by writing to PO Box 1026, Wellington, or sending a fax to 04-498 3597 or phoning 0800 252 464