Nelson Marlborough Health
TE WAIORA
We value: Respect - Integrity - Teamwork - Innovation

Human Resources Department
Nelson Hospital/Wairau Hospital

Name: ________________________ **Date:** ____________
(Please print clearly)

Place of Work ________________________

There are three (3) sections to this form. By signing the bottom of this form you are giving your consent to NMDHB collecting statistical information about you, giving the Payroll Office authority regarding your salary and payments due to you and giving your consent regarding Next of Kin. Please read all information carefully before signing.

1. EQUAL EMPLOYMENT OPPORTUNITY INFORMATION

NMDHB is committed to the principle and practice of Equal Employment Opportunity. We do not discriminate on the grounds of a person's colour, race, ethnic or national origin, sexual orientation, gender, age, family status, religion or ethical belief, political opinion, disability or marital status.

The following information is requested to collect statistical information to monitor our

- Equal Employment Opportunity practices
- Workforce composition

All information supplied will remain confidential to EEO matters within the Human Resources Section and will be held on your personal file. You could request to view this information at any time. Information collected on this form will not impact on any employment related decision.

Ethnicity:

☐ NZ Pakeha / European

☐ Maori ** Tribal affiliations (if known): ________________________)
**Are you happy to release this information the Director of Maori Health for the purposes of inviting you to join staff development days throughout the year? Please indicate below:*
☐ *Yes please release* ☐ *No do not release*

☐ Pacific Islands

☐ Other Ethnic Group **please specify** ________________________

☐ Not Declared

2. DIRECT CREDIT AND BANK DEDUCTION AUTHORITY (Proof of Acct No. required)

I hereby authorise the Payroll Office to:

1. DIRECT CREDIT my salary and payments due to me to:

Bank: ____________ **Branch:** ____________

Account No: ☐☐ ☐☐☐☐ ☐☐☐☐☐☐☐ ☐☐

2. DEDUCT from my salary $____________ each pay and deposit as follows:

Bank: ____________ **Branch:** ____________

Account No: ☐☐ ☐☐☐☐ ☐☐☐☐☐☐☐ ☐☐

3. INCREASE/DECREASE my deduction to: ____________ **by**

$ ________ each pay.

4. CEASE MY DEDUCTION TO: ____________

3. EMERGENCY CONTACT / NEXT OF KIN

This form is to allow Nelson Marlborough District Health Board to contact a person designated by you, in a case of emergency, should the need arise.

Name of Next of Kin: ________________________

Address: ________________________

Relationship: ________________________

Phone: ____________ (Home) ____________ (Work)

In terms of the Privacy Act, Nelson Marlborough District Health Board is not permitted to contact the abovenamed without your consent. I hereby give my consent to the designated person being called should it be deemed necessary.

Signed: ________________________ **Date:** ____________