Northern Regional Alliance Limited
Level 2, 650 Great South Road
Penrose 1051
PO Box 112147
Penrose, Auckland 1642
Phone **+64 9 631 1485**
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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 the Northern Regional Alliance, PO Box 112147, Penrose, Auckland 1642 or fax to (09)-589 3901 or email contractadmin@nra.health.nz

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 (i.e. which is to appear on Agreement documentation, Compulsory):	

Practice Trading Name:	

Physical Address of Practice (Compulsory):	

Postal Address (If different from above):	

Practice Phone Number:	
Practice Fax Number:	
Email Address:	

Authorised Signatory for Agreement (Print name, Compulsory):	

		Registration #
List of practitioners providing services under this Agreement (Compulsory):		

Start date for this Agreement (Compulsory):	

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

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

Direct Credit Details **PLEASE ATTACH A DEPOSIT SLIP WITH APPLICATION** (Must match with legal entity name)

GST Registration (Please tick the appropriate box)

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

☐	**No, I am not registered for GST.**

_____	_____	___/____/____	_____
Provider Name (Printed)	**Position**	**Date**	**Signature**

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)
☐	Yes, I have attached a Solicitor's Letter confirming purchase/sale of facility (if application is for a Change of Ownership)

Notes

1. The Northern Regional Alliance is managing approvals for Oral Health Agreements.
2. Contact the Northern Regional Alliance if you have a query - by phone: (09)-631 1485 or email contractadmin@nra.health.nz
3. Sector Services are responsible for all payments.
4. All inquiries about payments should be directed to Sector Services by writing to PO Box 1026, Wellington 6140, or fax to (04)-381 5344 or phone 0800 458 448.