NEW ZEALAND
CHIROPRACTIC BOARD
TE POARI KAIKOROHITI O AOTEAROA

Phone : +64 (4) 474 0703
Email : registrar@chiropracticboard.org.nz
Website : www.chiropracticboard.org.nz

Payment Form 2026/2027

This form is not to be used for a new Application for Registration.

Full name:	**Registration No:**

Tick required item/s All fees include GST

√	Payment for	Fee	Amount
	Annual Practising Certificate between 1 April and 31 October (first time only and already have registration) includes $100.00 Disciplinary Levy	$1103.25	
	Annual Practising Certificate between 1 November and 31 March (first time only and already have registration) includes $41.60 Disciplinary Levy	$449.60	
	Retain as non-practising	$100.00	
	Certificate of Registration	$30.00	
	*Certificate of Good Standing	$50.00	
	Copy of Register	$50.00	
		TOTAL	

*** To ensure your request is not delayed, please ensure you complete all sections of this form.**

APPLICANT SIGNATURE _____

DATE _____

Chiropractors are required to inform the Board of changes to their contact details. Please use this section to notify the Board of your current addresses:

Current Residential Address:	**Current Postal Address:**

- Work addresses and work telephone numbers form part of the Public Register. You may object to the publication of this information by putting your objection in writing to the Board.

Current Work Address:	**Current Work Telephone Number:**

- The Board utilises email to contact registrants and disseminate information. Please provide your email address below.

Current e-mail address:

- The Board requires after hours and mobile numbers for its own records. These details do not form part of the Public Register and will not be released.

Current contact telephone numbers: (Board use only – not for publication)
Home : Mobile :

DOCUMENT DELIVERY

If you have requested a Certificate of Good Standing, please complete the following details:

To be sent to: _____

_____

_____

Attention of: _____

PAYMENT DETAILS

Please ensure you complete the payment details on the following page and sign where indicated.

Credit Card Payment

Please debit my (tick one) ☐ Visa ☐ MasterCard ☐ Bankcard for the following amount/s:

☐ $..... (Total transferred from front page)

Credit Card Number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiry Date: _____ / _____ (month/year)

Cardholder's Name: _____

Cardholder's Signature: _____

REMEMBER TO KEEP COPIES OF YOUR APPLICATION FORM AND ALL ACCOMPANYING DOCUMENTS

Post this application and any supporting documentation to:

The Deputy Registrar
Chiropractic Board
P O Box 9644
Wellington 6141
New Zealand