

GeoStan NZ REQUEST FORM

Please complete this form to apply for GeoStan NZ approval

Type of Request		
<input type="checkbox"/> GeoStan NZ address geocoding application <input type="checkbox"/> GeoStan NZ Software Development Kit (SDK) for embedding into other applications		
Organisation Details		
Organisation Name:		
Physical Address:		
Post Code:		
Phone Number:		Fax Number:
Email Address:		
Primary Contact Person's Name (please print):		
Signature:		Date:
IT contact details (<i>Critchlow will contact this person if they have any questions with regard to your installation</i>)		
Technical Liaison:		
Telephone Number:		Fax Number:
Email Address:		
GeoStan Data Updates contact details (<i>Critchlow will supply updates on CD quarterly</i>)		
Contact Person (if different from primary contact person):		
Phone Number:		
Email Address:		
Postal Address:		
Post Code:		
Deployed Operating System		
<input type="checkbox"/> Windows 2000 <input type="checkbox"/> Windows 7 <input type="checkbox"/> Windows Server 2007	<input type="checkbox"/> Windows XP <input type="checkbox"/> Windows Server 2000 <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Windows Vista <input type="checkbox"/> Windows Server 2003
Front end software application		
<input type="checkbox"/> Medtech <input type="checkbox"/> Profile <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> MedCen <input type="checkbox"/> Profile for Mac	<input type="checkbox"/> Next Generation <input type="checkbox"/> My Practice

Authorisation Details

1) Name of the specified organisation you are contracted to provide health or disability services to (e.g. PHO):

2) Your contract number (if known)

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3) Start date of contract _____ 4) Expiry date of contract _____

MOH use only

Application received:

Approved/Not Approved

Name:

Designation:

Date:

Response to Critchlow:

Type of Organisation

- | | |
|--|--|
| <input type="checkbox"/> Medical Practice | <input type="checkbox"/> Specialist Clinic (incl radiology, surgical, eye, physio etc) |
| <input type="checkbox"/> Primary Health Organisation | <input type="checkbox"/> Laboratory |
| <input type="checkbox"/> Single Practitioner | <input type="checkbox"/> Midwife |
| <input type="checkbox"/> Community Health Service | <input type="checkbox"/> Management Support Organisation |
| <input type="checkbox"/> Community Hospital | <input type="checkbox"/> Needs Assessment Service Co-ordination agency |
| <input type="checkbox"/> Breast Screening Unit | <input type="checkbox"/> Non-Governmental Organisation |
| <input type="checkbox"/> Optometrist | <input type="checkbox"/> Private Accident and Emergency clinic |
| <input type="checkbox"/> Pharmacy | <input type="checkbox"/> Private Hospital |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Shared Service Agency |
| <input type="checkbox"/> District Health Board | <input type="checkbox"/> Ministry of Health |
| <input type="checkbox"/> Other (specify) _____ | |

Requestor Advised: _____ Date: _____

Health Facility Code

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Facility ID

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Organisation ID

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HPI CPN(s) _____