

Membership Application

SIGNING OFFICER USE ONLY

Date Received _____

Cheque Cash

Amount \$ _____

Receipt No. _____

District/Region _____

Membership No. _____



Membership Type:

- New
 Renewal

Membership Category:

- Active
 Associate

Renewal Year:

July 1, 20__ to
June 30, 20__

Last Name _____ First Name _____

Address _____ City _____ Postal Code _____

Phone _____ Home Email _____

Employer/Hospital _____ Work Phone _____

Work Fax _____ Work Email _____

Employment Status

- Employed
- Full-time
 - Part-time
 - Casual
- Seeking Employment
 Retired
 Other

Current Area of Practice:

- Staff Nurse
 Education
 Clinical Resource
 Management
 Research
 RNFA
 PN(A)
 Other Specify _____

College of Nurses Registration Number _____

CPN Certification

- Yes If Yes, Specify Year Certified _____ and Certification Number _____
 No

RNAO

- Yes If Yes, Specify Membership Number _____
 No

Education (Check all that apply)

- Diploma Post-Graduate OR Course Baccalaureate Master's PhD
Currently enrolled in an educational program? Yes No