



ABORIGINAL NURSES ASSOCIATION OF CANADA

16 Concourse Gate Unit 600 Ottawa ON K2E 7S8

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Website: www.anac.on.ca

MEMBERSHIP

APPLICATION/RENEWAL FORM

April 1, 2012 to March 31, 2013

PERSONAL INFORMATION

Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Mr. <input type="checkbox"/> Dr. <input type="checkbox"/>	Given name			Last name		
Home mailing address						
City				Prov/Terr	Postal Code	
Employer/School				Department		
Address						
Home telephone ()		Work/School ()		ext	Cell ()	Fax ()
Home e-mail**			Work e-mail**			

****An e-mail address must be provided to facilitate registration to access the Members' Only Section of the A.N.A.C. website.****

EDUCATION

Provincial RN Registration No. _____ BSc (Nursing)
 (RN number must be included where applicable) Certificate(s) _____
 Masters (indicate program) _____ PhD (indicate program) _____

PLEASE SELECT

MEMBER OF CNA OR AFFILIATE *(Information REQUIRED on an annual basis)*

Member: NEW RENEWING

YES Name of affiliate: _____ NO

MEMBERSHIP CATEGORIES

Regular \$60 (Please specify categories)

RN LPN Other Profession (please specify) _____

Nursing Student \$20

Ancestry must be specified - First Nations Inuit Métis non-Aboriginal **Status #** _____

SELECT ALL AREAS OF INTEREST:

- | | | |
|---|--|--|
| <input type="checkbox"/> Adolescent Health | <input type="checkbox"/> Health Promotion | <input type="checkbox"/> Sexuality & Reproductive Health |
| <input type="checkbox"/> Chronic Diseases (e.g. Diabetes) | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Smoking Cessation |
| <input type="checkbox"/> Community Health/Development | <input type="checkbox"/> Home Care | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Disability | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Traditional Healing |
| <input type="checkbox"/> Environmental Health | <input type="checkbox"/> Mentoring Aboriginal Nursing Students | <input type="checkbox"/> Trans-Cultural Nursing |
| <input type="checkbox"/> Family Violence | <input type="checkbox"/> Perinatal/Maternal Child Health | <input type="checkbox"/> Women's Health |
| <input type="checkbox"/> FAS/FAE | <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Other: _____ |

Method of payment

OFFICE USE ONLY

Cheque/Money Order - **Made payable to: Aboriginal Nurses Association of Canada**

RECEIPT # _____

Visa MasterCard

Name on Card (please print): _____

USERID: _____

Enter credit card # and expiry date:

PASSWORD: _____

APPLICANT'S SIGNATURE

APPLICATION DATE: