



# ABORIGINAL NURSES ASSOCIATION OF CANADA

56 SPARKS STREET, SUITE 502, OTTAWA, ONTARIO K1P 5A9

Tel: (613) 724-4677 Toll free: (866) 724-3049

Fax: (613) 724-4718

# MEMBERSHIP

APPLICATION/RENEWAL FORM

April 1, 2010 to March 31, 2011

Website: [www.anac.on.ca](http://www.anac.on.ca)

PERSONAL INFORMATION		EMPLOYER / SCHOOL INFORMATION	
Last name		Name	
Given name		Department	
Mailing address		Mailing address	
Telephone ( )		Telephone ( )	
Cell phone ( )		Cell phone ( )	
Fax ( )		Fax ( )	
E-mail		E-mail	

**(As a security measures for Members' Only Section registration and to ensure member contact an e-mail address must be provided.)**

EDUCATION	INDICATE AREA(S) OF INTEREST
<input type="checkbox"/> Provincial RN Registration No. _____ <b>(RN number must be included for REGULAR membership to be processed)</b> <input type="checkbox"/> BSc (Nursing) <input type="checkbox"/> Masters (indicate program) _____ <input type="checkbox"/> PhD (indicate program) _____ <input type="checkbox"/> Certificate(s) _____	<input type="checkbox"/> Adolescent Health <input type="checkbox"/> Chronic Diseases (e.g. Diabetes) <input type="checkbox"/> Community Health/Development <input type="checkbox"/> Disability <input type="checkbox"/> Environmental Health <input type="checkbox"/> Family Violence <input type="checkbox"/> FAS/FAE <input type="checkbox"/> Health Promotion <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Home Care <input type="checkbox"/> Mental Health <input type="checkbox"/> Mentoring Aboriginal Nursing Students <input type="checkbox"/> Perinatal/Maternal Child Health <input type="checkbox"/> Sexual Abuse <input type="checkbox"/> Sexuality & Reproductive Health <input type="checkbox"/> Smoking Cessation <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Traditional Healing <input type="checkbox"/> Trans-Cultural Nursing <input type="checkbox"/> Women's Health <input type="checkbox"/> Other: _____
PLEASE SELECT	
Member type: <input type="checkbox"/> NEW <input type="checkbox"/> RENEWING	
Other membership: <input type="checkbox"/> C.N.A. member <input type="checkbox"/> Other:	
Ancestry: <input type="checkbox"/> First Nations <input type="checkbox"/> Inuit <input type="checkbox"/> Métis <b>Status #</b> _____	
MEMBERSHIP CATEGORIES	
<b>Regular \$60</b> (Please specify category) <input type="checkbox"/> RN Aboriginal Ancestry <input type="checkbox"/> RN Non-Aboriginal <input type="checkbox"/> LPN Aboriginal <input type="checkbox"/> LPN Non-Aboriginal <input type="checkbox"/> Other-please specify: _____ <input type="checkbox"/> Aboriginal <input type="checkbox"/> Non-Aboriginal	
<b>Nursing Student \$20</b> <input type="checkbox"/> Aboriginal <input type="checkbox"/> Non-Aboriginal	

Method of payment:	OFFICE USE ONLY
<input type="checkbox"/> Cheque/Money Order <b>Made payable to: Aboriginal Nurses Association of Canada</b> <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard	RECEIPT # _____ USERID: _____ PASSWORD: _____
Name on Card (please print): _____ Enter credit card # and expiry date: _____ - _____ - _____ exp. ____/____	
APPLICANT'S SIGNATURE _____	
APPLICATION DATE: _____	