Unity and Strength Through Caring
CATSIN

Congress of Aboriginal and Torres Strait Islander Nurses
ABN: 64 085 000 120

Membership Application Form

Membership year ends 30th September

Treat This form as your Tax Invoice

Sections 1 and 3 are compulsory

(SECTION 1)

Please print all details clearly

1. Contact Details

Title: ☐ Dr. ☐ Professor ☐ Mr ☐ Mrs ☐ Ms ☐ Miss

Surname: ……...

First Name & Initial: ……

Postal Address: ……

……

……Post Code:……

Phone: (Home)……

(Mobile)……

(Work)……..

Fax: ……

Email Address: ……

……

2. Personal Details

I identify as:

☐Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander

(* please note you must be Aboriginal and/or Torres Strait Islander to become a member*)

Gender: ☐ Male ☐ Female Age: ……. Date of birth:..……/…..…/……

3. Type of membership you are applying for?

(* Please note: membership year expires 30th September)

Full Membership: (registered and enrolled nurses & midwives) ☐ $ 60.00pa

Associate Membership: (student and retired registered nurses & midwives) ☐ $ 20.00pa

********** **Membership fees are tax deductible!** **********

4. Professional /Student Details

Section A (registered, enrolled or retired registered nurses & midwives)

Registration Number: ……

***Please enclose a copy of your Annual Practicing Certificate/Registration ***

If retired, in what year did you retire? ……..

Qualifications: …….….

……..

Professional Status: ……..

Place of Employment: ……..

Section B (student nurse or student midwife)

Place of Study: …….

Are you a: ☐ Full-time student ☐ Part-time student

In what year did you commence your studies? ……..

In what year will you complete your studies? …….…

If employed, place of employment: ……

Member Profile

This section is only to provide you with a better service and to understand the issues that concern you. Please fill in as little or as much of the section as you would like.

(SECTION 2)

1) CURRENT EMPLOYMENT SECTOR

☐ Public Health ☐ Specialist (please specify) ☐ Aboriginal Health Service

☐ Student ☐ Government/state/territory ☐ Academic/Education

☐ Research ☐ Hospital ☐ Other (please specify)

Please Specify……..
……
……

2) PRIMARY LOCATION OF WORK

☐ City ☐ Urban ☐ Rural ☐ Remote

☐ NSW ☐ QLD ☐ VIC ☐ NT ☐ W A ☐ TAS ☐ TSI ☐ SA

3) PRIMARY PLACE OF WORK

Please specify the orgnisation you currently work for…….
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……..

4) JOB FUNCTION

☐Student ☐ Midwife ☐ Lecturer

☐Nurse ☐ Consultant ☐ Other (please specify)

Please specify……..
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5) QUALIFICATIONS/EDUCATION/OTHER POSITIONS

Please list……..
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6) PROFESSIONAL INTERESTS

□ Indigenous Health	□ Ethical Issues	□ Midwifery	□ Education
□ Women's Health	□ Men's Health	□ Cultural Issues	□ Sexual Health
□ Mental Health	□ Child Health	□ Drug and Alcohol	□ Other

Please Specify
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7) MEMBERSHIP OF OTHER BODIES

Please List Other Bodies
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8) INDIVIDUAL AND FAMILY HISTORY

Please tell us as little (or as much) about yourself and your family history as you would like; for example: Where is your land? Who are your people? What made you choose nursing as a career?
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You may also like to include a photograph of yourself.

Attach
Photo Here

Photograph Attached: ☐ Yes ☐ No (this is not compulsory)

9) WHY HAVE YOU CHOSEN TO BECOME A MEMBER OF CATSIN?

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10) PREFERED METHOD OF COMMUNICATION

☐ Phone ☐ Fax ☐ Email ☐ Mail

Please indicate how quickly you are able to respond, using this method of communication……
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11) COMMENTS AND SUGGESTIONS

Please provide any comments and suggestions you may have in regard to your membership or CATSIN in general. (you may also use this space if you need more space to answer other questions)

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Payment Details and Declaration

Treat this Form as Your Tax Invoice

(SECTION 3)

I enclose a cheque or money order (Made payable to CATSIN)
For the amount of $……..

Payment can also be made directly into our bank account:

BSB Number : 034 119

Account Number: 233552

Account name: Congress of Aboriginal and Torres Strait Islander Nurses Limited

Bank: Westpac

Please ensure you include your name on the deposit

Declaration: ***membership cannot be accepted until this section is signed***

To the best of my knowledge, all the information I have provided in this membership application is true and correct. I understand that it is my responsibility to inform CATSIN of any changes to my contact details or if my professional/student situation should change.

Signature:……Date:……/……../……

PRIVACY STATEMENT:

CATSIN is committed to protecting the privacy and security of Personal Information, which it holds about you. The Personal Information, which you provide us with in this form, will be used only by CATSIN to:

- Update your member profile;
- Tailor and target information which you receive from us;
- Provide you with access to and information about a range of current and future member benefits; and
- Conduct market research in order to identify and analyse the ongoing needs of CATSIN members

You have the right to access any Personal Information CATSIN holds about you, subject to exceptions in any applicable privacy legislation. You may also request correction of information, which is out of date or inaccurate.

Thank you for your application, you will be hearing form us shortly ☺

**********Office Use Only**********

Date Received:……./……../…….

Approved:……Date:……./……../……
(must be signed by a member of the Executive)

Membership Expires on……/……/……

Unapproved/further details sort?……..
……..
……..
Membership information sent on:……./……../…….

Congress of Aboriginal and Torres Strait Islander Nurses Limited (CATSIN)
ABN: **64 085 000 120**
Executive Director: Sally S Goold OAM
Postal Address: 14 Cassia Ave, Banksia Beach Qld 4507
Ph: (07) 3410 7236 **Mobile**: 0438 808 739 **Fax:** (07) 3410 7235
Email: catsin@bigpond.net.au **Web:** www.indiginet.com.au/catsin