

**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

Please print all details clearly

(SECTION 1)

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:

.....

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

- | | | |
|--|--|--|
| <input type="checkbox"/> Public Health | <input type="checkbox"/> Specialist (please specify) | <input type="checkbox"/> Aboriginal Health Service |
| <input type="checkbox"/> Student | <input type="checkbox"/> Government/state/territory | <input type="checkbox"/> Academic/Education |
| <input type="checkbox"/> Research | <input type="checkbox"/> Hospital | <input type="checkbox"/> Other (please specify) |

Please Specify.....
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2) PRIMARY LOCATION OF WORK

- City Urban Rural Remote
- NSW QLD VIC NT WA TAS TSI SA

3) PRIMARY PLACE OF WORK

Please specify the organisation you currently work for.....
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4) JOB FUNCTION

- Student 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

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Indigenous Health | <input type="checkbox"/> Ethical Issues | <input type="checkbox"/> Midwifery | <input type="checkbox"/> Education |
| <input type="checkbox"/> Women's Health | <input type="checkbox"/> Men's Health | <input type="checkbox"/> Cultural Issues | <input type="checkbox"/> Sexual Health |
| <input type="checkbox"/> Mental Health | <input type="checkbox"/> Child Health | <input type="checkbox"/> Drug and Alcohol | <input type="checkbox"/> Other |

Please Specify

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7) MEMBERSHIP OF OTHER BODIES

Please List Other Bodies

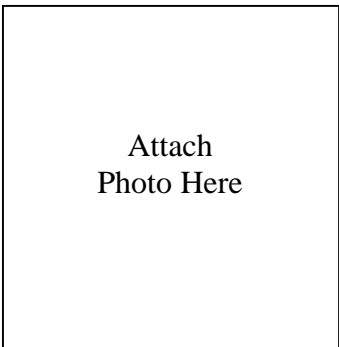
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8) INDIVIDUAL AND FAMILY HISTORY

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.



Photograph Attached: Yes No (this is not compulsory)

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

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10) PREFERRED 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 \$.....

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 from 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

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