

## DECLARATION

Please read the declaration carefully and tick the appropriate box.

I am a Registered Nurse or RN Div 1 Nurse

Year qualified  
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I am an Enrolled Nurse or RN Div 2 Nurse

Year qualified  
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I, the undersigned hereby apply to be accepted as a member of Royal College of Nursing, Australia and to use the post nominal MRCNA.

I have read and understood the Mission and Objectives of Royal College of Nursing, Australia and I fully support them. As a member I will endeavour to work for the achievement of the College's Mission and Objectives in my nursing practice.

I agree to pay and be liable for the Annual Subscription amount as determined by the Board from time to time.

I declare that I am a registered or enrolled nurse according to the information detailed on this form and I accept to be bound by the Articles of Association and Regulations of Royal College of Nursing, Australia and by the decisions of the College Board. I understand that all information sought by the Board of Royal College of Nursing, Australia, or any Committee of the College, in relation to my application shall for all purposes remain confidential.

State of Registration: \_\_\_\_\_

Registration Number: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Register me to receive:

Nurse Leaders Bulletin (fortnightly by email)

Student Bulletin (monthly by email)

Rural and Remote Bulletin (monthly by email)

Please enrol me in 3LP  send updates by email

I elect to receive *Connections* by email

I elect NOT to receive a printed copy of the College's future Annual Reports, however I will still receive all other member mailings including notices of meetings and proxy forms

## NATIONAL NURSING NETWORKS (NNNs)

Membership includes free enrolment in any of the NNNs.

YES please include my contact details in the annual network directory

### Tick preferred NNN

Breast Care

Clinical Information

Community and Primary Health Care

Ethics

Gerontic

History

Legal Issues

Nurses in Business

Leadership

Nurse Practitioner

Palliative Care

Research

Transcultural Nursing

## YOUR REASONS FOR JOINING RCNA

### Please tick those boxes which apply:

Networking

Scholarship application

Required by employer

Member discounts

Professional information

P.I. Insurance

Continuing education

Policy voice

Career development

3LP

Professional status

## HOW DID YOU RECEIVE THIS FORM?

Presentation at work

Workshop/seminar

With pay slip

Conference/expo

In the mail

From a colleague

Other \_\_\_\_\_

## SUBSCRIPTION

College membership subscription is \$317 per annum (inc. GST)  
For your convenience we offer the following methods of payment:

(Please tick the appropriate box)

Credit card payment

\$27.50 per month (inc. GST & admin. fee)

\$317 per year (inc. GST)

Direct Debit \$27.50 per month (inc. GST & admin. fee) *see over*

Cheque/Money Order/Cash \$317 (inc. GST)

*Prices correct as at 16 December 2003*

## CREDIT CARD AUTHORISATION

Surname: \_\_\_\_\_

First Name(s): \_\_\_\_\_

I hereby authorise Royal College of Nursing, Australia to charge my credit card automatically upon receipt of this authorisation for membership subscription.

In the event of changes to membership subscription I authorise Royal College of Nursing, Australia to alter the amount from the appropriate date accordingly. Alterations to membership subscription shall be notified in writing by Royal College of Nursing, Australia in advance of effective dates.

### Type of Credit Card (please tick)

Amex

Bankcard

Mastercard

Visa

### Credit Card Number:

-----

Expiry date: \_\_\_\_/\_\_\_\_

Name on card: \_\_\_\_\_

Signature of cardholder: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



ABN 69 004 271 103

## Direct Debit Request



Request and Authority to debit the account named below to pay Royal College of Nursing, Australia

### Request and Authority to debit

Surname or company name: \_\_\_\_\_

Given names or ACN/ARBN: \_\_\_\_\_ (“you”)

request to authorise Royal College of Nursing, Australia (user ID no 73854) to arrange for any amount Royal College of Nursing, Australia may debit or charge you to be debited through the Bulk Electronic Clearing System from an account held at the financial institution identified below subject to the terms and conditions of the Direct Debit Request Service Agreement [and any further instructions provided below]

### Insert the name and address of financial institution at which account is held

Financial institution name: \_\_\_\_\_

Address: \_\_\_\_\_

### Insert details of account to be debited

Name of account: \_\_\_\_\_

BSB number    -

Account number

### Acknowledgement

By signing the Direct Debit Request you acknowledge having read and understood the terms and conditions governing the debit arrangements between you and Royal College of Nursing, Australia as set out in this request and in your direct debit request service agreement.

The first debit may be made on/or after \_\_\_/\_\_\_/\_\_\_ and monthly intervals after that.

### Insert your signature and address

Signature: \_\_\_\_\_

(if signing for a company, sign and print full name and capacity for signing eg. director)

Address: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_

## ARE YOU RECOGNISED BY YOUR PEERS AS AN EXPERT?

Yes, I would like to contribute or represent the College in my area of expertise.

Please list your area(s) of **expertise** to assist RCNA when inviting member contributions and representation for policy work:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## PRIVACY STATEMENT

In this Privacy Statement, “Personal Information” has the same meaning as in the Privacy Act 1988 (Cth).

RCNA is committed to protecting the privacy and security of the Personal Information which it holds about you.

The Personal Information which you provide us with in this Application Form will be used by RCNA to:

- Process your application for membership subscription with RCNA;
- Manage your membership of RCNA;
- Ensure your compliance as a member, with RCNA’s Constitution and By-laws;
- Conduct market research in order to identify and analyse the ongoing needs of RCNA members; and
- Provide you with access to and information about a range of special offers, products and services.

If you do not provide us with this Personal Information, we may not be able to process your application.

RCNA may disclose the Personal Information which you provide us with in this Form to external service providers to whom we have contracted out functions, such as printers and mailing houses, but only for the purposes of providing membership services.

You have the right to access any Personal Information which RCNA holds about you, subject to the exceptions in the Privacy Act 1988. You may also request the correction of information which is inaccurate. Access and/or correction requests can be made through RCNA Membership Freecall 1800 061 660.

For more information on RCNA’s Privacy Policy, visit our website at [www.rcna.org.au](http://www.rcna.org.au)

If you do not wish to receive information about special offers, products and services, please tick this box.

### PLEASE RETURN THIS APPLICATION FORM TO:

Membership Department, Royal College of Nursing, Australia  
Reply Paid 219 DEAKIN WEST ACT 2600 (no stamp required)

Ph: 02 6282 5633 Tollfree: 1800 061 660

Fax: 02 6282 3565 Email: [canberra@rcna.org.au](mailto:canberra@rcna.org.au)

Visit our Web Page: [www.rcna.org.au](http://www.rcna.org.au)



ABN 69 004 271 103

Royal College of Nursing, Australia

# Membership\*

# Application Form



RCNA Affiliated Member of ICN

## PERSONAL PROFILE

Please use block letters

Title: (please circle) Dr/Mrs/Miss/Ms/Mr/Other \_\_\_\_\_

Surname: \_\_\_\_\_

Given names: \_\_\_\_\_

*Please note: Home addresses are preferred*

Postal address: \_\_\_\_\_

Suburb: \_\_\_\_\_

State: \_\_\_\_\_ Postcode: \_\_\_\_\_

Phone W: (\_\_\_\_) \_\_\_\_\_

Phone H: (\_\_\_\_) \_\_\_\_\_

Fax: (\_\_\_\_) \_\_\_\_\_

Mobile: \_\_\_\_\_

Email: \_\_\_\_\_

Place of employment (in full): \_\_\_\_\_

Position Title: \_\_\_\_\_

Dept: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

### Post registration qualifications:

Course/subject	Qualification type (eg PhD, Diploma)	Date Completed

### Key area(s) of practice:

Clinical  Management  Education  Research

Other: \_\_\_\_\_