



**Branch  
Application for Membership  
2010**

First Name: \_\_\_\_\_

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

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

Name of GP: \_\_\_\_\_

\_\_\_\_\_

\*\* Work Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Tel (home): \_\_\_\_\_

\_\_\_\_\_

Tel (work): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

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

Would you like to receive **text alerts** from the National Executive Committee (NEC)?\*  YES  NO

E-mail address: \_\_\_\_\_

Would you like to receive **e-mail alerts** from the National Executive Committee (NEC)?\*  YES  NO

\*i.e. Relevant info via IPNA Admin, e.g. Alerts from health agencies, disease outbreaks, courses, discussion boards, etc.

<b>PREFERRED MAILING ADDRESS FOR IPNA USE: (Including Journal)</b>	<input type="checkbox"/> Home	<input type="checkbox"/> Work
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<b>IF YOU WOULD LIKE TO RECEIVE INFORMATION AT THE ABOVE MAILING ADDRESS FROM OUTSIDE BODIES ON ISSUES RELEVANT TO PRACTICE NURSING, PLEASE SIGN HERE:</b>
Signature: _____
This information may relate to education, study days, continuing professional development, products or services that are deemed by the National Executive Committee to be relevant to the role of the Practice Nurse.

<b>Do you give us permission to pass on your work contact details (Address and telephone number) to your local Professional Development Coordinator for Practice Nurses?</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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\*\*An Bord Altranais PIN number: \*\*  (photocopy of current registration certificate must be attached)

**Professional Qualifications (ABA Divisions)**

RGN     RM     RSCN     RPN     RMHN     RNID     RPHN     RNP

**Further Education:** (please specify, e.g. *Diploma Asthma, Higher Diploma in Practice Nursing*).

I.F.P.A Cert in Family Planning \_\_\_\_\_

Other Nursing Certificates \_\_\_\_\_

Diploma \_\_\_\_\_

Degree \_\_\_\_\_

Higher Diploma \_\_\_\_\_

Masters \_\_\_\_\_

**Nursing Grade:** CNS  Year CNS accredited:   ANP Year ANP accredited:

**Special Interest Areas:**

Women's Health  Diabetes  Asthma  Cardiovascular Disease

Other  
(Please specify): \_\_\_\_\_

**Hours worked per week:**

**Union Membership:** INO  SIPTU  IMPACT

**Medical Indemnity:** MDU  MEDISEC  Medical Protection Society

**Signed:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**\*\* Work address and An Bord Altranais P.I.N. MUST be completed in order for your application to be processed. If you do locum work please indicate this and also give the name and address of the last GP you worked with and the date of that locum cover.**

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**FOR OFFICIAL USE ONLY**

Received

Entered