



Application for IPNA Membership 2012

_____ Branch

Have you been a member of the IPNA within the past 2 years? Yes No

First Name: _____

Surname: _____

Home Address: _____

Name of GP: _____

** Work Address: _____

Tel (home): _____

_____ (you must be working with a GP to qualify for membership)

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.

PREFERRED MAILING ADDRESS FOR IPNA USE:
(Including Journal)

Home

Work

IF YOU WOULD LIKE TO RECEIVE INFORMATION AT THE ABOVE MAILING ADDRESS FROM OUTSIDE BODIES ON ISSUES RELEVANT TO PRACTICE NURSING, PLEASE SIGN HERE:

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.

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?

Yes

No

**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.

Payment of Membership Fee

Please send your completed application form, photocopy of ABA Cert showing that you are an RGN and a cheque / postal order / bank draft for €75 made out to "Irish Practice Nurses Association" to Tracey at the address below.

**Tracey Rooney, IPNA Membership Secretary,
Dundrockan, Donaghmoynne, Carrickmacross, Co Monaghan.**

FOR OFFICIAL USE ONLY

Received

Entered