



**AUSTRALIAN ASSOCIATION OF  
STOMAL THERAPY NURSES**

ABN 16 072 891 322

**AFFILIATE MEMBERSHIP  
APPLICATION FORM**

Name:		
Employer:		
Job Title:		
Professional Title (eg RN):		
Workplace Address:		
Suburb:	Post Code:	State:
Work Phone (including area code):		
Work Email:		
Which state(s) do you primarily work in?:		

Title of Stomal Therapy Nursing Qualification:	
Education facility:	
Country:	Year Gained:
AHPRA Registration:	

Do you offer outpatient stomal therapy services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you consent to your name and workplace details being displayed on the 'Find a Stoma Nurse' page on the AASTN website?	<input type="checkbox"/> Yes <input type="checkbox"/> No

- I have attached a copy of my Stomal Therapy Nursing Qualification
- I have current AHPRA nursing registration as a Registered Nurse
- I agree to be bound by the AASTN Constitution
- I agree to the release of mailing information + workplace contact details to AASTN State branches for AASTN purposes

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

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

Email the signed, completed application form and a copy of your Stomal Therapy Qualification to:  
[membership@stomalthrapy.au](mailto:membership@stomalthrapy.au)



**Membership fees to be paid  
via the AASTN website**