AUSTRALIAN ASSOCIATION OF STOMAL THERAPY NURSES

ABN 16 072 891 322

ASSOCIATE MEMBERSHIP APPLICATION FORM

Name:		
Postal Address:		
Suburb:	Post Code:	State:
Phone:		
Email:		

Place of Employment:		
Professional Category and Title:		
Workplace Address:		
Suburb:	Post Code:	State:
Work Phone (including area code):		
Work Email:		
AHPRA Registration (If applicable):		

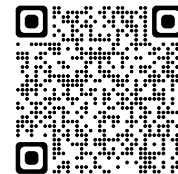
☒ I agree to be bound by the AASTN Constitution

☐ 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 to:
membership@stomaltherapy.au



Membership fees to be paid via the AASTN website