



**AUSTRALIAN ASSOCIATION OF
STOMAL THERAPY NURSES**

ABN 16 072 891 322

**ASSOCIATE STUDENT
MEMBERSHIP APPLICATION FORM**

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

| | | |
|---|------------|--------|
| Place of Employment: | | |
| Professional Title: eg RN, CN, CNC, NP etc | | |
| Workplace Address: | | |
| Suburb: | Post Code: | State: |
| Work Phone (including area code): | | |
| Work Email: | | |

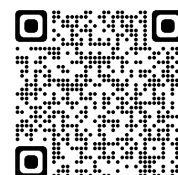
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|--|
| Title of Stomal Therapy Nursing Qualification you are enrolled in: |
| Education facility: |
| Country: |
| AHPRA Registration Number: |

- 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 to:
membership@stomalthrapy.au



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