AASTN
Australian Association of Stomal Therapy Nurses
stoma / wound / continence

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:		

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@stomaltherapy.au

Membership fees to be paid via the AASTN website