



**AUSTRALIAN ASSOCIATION OF
STOMAL THERAPY NURSES**
ABN 16 072 891 322

**COMMERCIAL 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?:		

- 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@stomatherapy.au



Membership fees to be paid
via the AASTN website