CANAC ACIIS
CANADIAN ASSOCIATION OF NURSES IN HIV/AIDS CARE
L' ASSOCIATION CANADIENNE DES INFIRMIÈRES ET INFIRMIERS EN VIH/SIDA

2015/16 GROUP MEMBERSHIP APPLICATION / RENEWAL FORM

Please print all information clearly

Group Contact Information

Organization: _____

Street Address: _____

City: _____ Province: _____

Postal Code: _____ Country: _____

Preferred Language: ☐ English ☐ French

Group Demographics

Percentage of your organizations work in HIV / AIDS:

☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100%

Practice Setting (Check all that apply)**:**

☐ Inpatient
☐ Outpatient / Ambulatory
☐ Public Health
☐ Community Health Care
☐ College / University
☐ Other (Please specify) _____

☐ Addictions Treatment Centre
☐ Psychiatric / Mental Health
☐ Jail / Government Corrections
☐ Long-Term / Extended Care
☐ Community-Based / Non-Profit Organization

☐ Hospice
☐ Home Care
☐ Physician's Office
☐ Private / Group Practice

Work setting: ☐ Rural ☐ Suburban ☐ Urban ☐ Mixed

Characteristics of Patient/Client Population (Check all that apply)**:**

☐ Aboriginal communities
☐ Gay / Bisexual Men
☐ Ethnic communities
☐ Incarcerated (Jail / Prison)
☐ Refugees / Immigrants
☐ Other (Please specify) _____

☐ Injecting Drug / Substance Users
☐ Heterosexual Women / Men
☐ Transgender
☐ Homeless / Street involved
☐ Hemophiliacs / Transfusion/Transplant Recipients

☐ Pregnant Women
☐ Children
☐ Youth

Fee structure

Fees are based on the number of people registered for membership; all members must be registered at the same time and work for the same organization. Non-nurses and students can also be group members.

Number of Members	Cost per member	Discount represented
1 – 20	$50 each	n/a
> 20	$40 each	20%

Your cost:

# of Members registered: _____

Cost per member: _____

Total Fee: _____

Member Information

(please fill out for each individual in the group who will be receiving membership privileges)

Name: _____

Email: _____

Phone: _____

Professional Qualification

☐ Registered Nurse ☐ Nurse Practitioner ☐ LPN ☐ RPN ☐ Psychiatric Nurse

☐ Other: _____

☐ Student (Programme): _____

☐ Total number of years in Nursing: _____

☐ Total number of years in HIV:

Primary Position

☐ Staff Nurse / Nurse Clinician	☐ Nurse Educator	☐ Case Manager / Patient Coordinator
☐ Clinical Nurse Specialist	☐ Nurse Researcher	☐ Infection Control Practitioner
☐ Nurse Practitioner	☐ Manager / Unit Coordinator	☐ Consultant
☐ Clinical Trials Nurse	☐ Director / Assistant director	☐ Counselor / Therapist
☐ Sales / Marketing Industry Rep	☐ Other (please specify):	

General Information

Are you a member of:	**RNAO:**	☐ Yes	☐ No	**ANAC:**	☐ Yes	☐ No
Are you an AIDS Certified Registered Nurse (ACRN – available in the US only)					☐ Yes	☐ No
Would you apply if Canadian Certification were available?					☐ Yes	☐ No
May we share your contact information with other CANAC members?					☐ Yes	☐ No
Do you wish to be included in mailing lists approved for external use?					☐ Yes	☐ No

Name: _____

Email: _____

Phone: _____

Professional Qualification

☐ Registered Nurse ☐ Nurse Practitioner ☐ LPN ☐ RPN ☐ Psychiatric Nurse

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