



Membership Application Form

Please complete the membership form below and submit to the address below, along with the \$41 membership fee to become a member of the Association of Registered Psychiatric Nurses of BC.

SECTION I: CONTACT INFORMATION

TITLE:	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Dr <input type="checkbox"/> Prof. <input type="checkbox"/> Other, specify:		
FIRST NAME:		LAST NAME:	
ADDRESS:		HOME TELEPHONE:	
		WORK TELEPHONE:	
		CELLULAR TELEPHONE:	
TOWN/CITY:		OTHER PHONE:	
POST CODE;		PRIMARY EMAIL:	
COUNTRY;		SECONDARY EMAIL:	
RPN Graduation School & Year:			
Other nursing registrations:			
RPN Status:	<input type="checkbox"/> Practicing <input type="checkbox"/> Non-Practicing <input type="checkbox"/> Retired <input type="checkbox"/> Student		
Are you interested in assisting the Association?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Volunteer area of interest:	
How did you hear about this ARPNBC?	<input type="checkbox"/> Direct Email <input type="checkbox"/> Websites (Please Specify) : <input type="checkbox"/> Other (Please Specify) :		

Declaration: I agree that the above information is correct and that I am currently eligible to make this application for ARPNBC membership.

SIGNED:		DATE:	
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PLEASE NOTE: Receipts will be provided but are currently not tax deductible.

Print off and mail this application form along with your \$41 application fee to:

ARPNBC
 #100 - 1450 Creekside Drive, Vancouver, BC V6J 5B3