

		Membership Application	
Personal Information			
First Name:		Last Name:	
Mailing Address:			
City:			
Province:		Postal Code:	
Daytime Phone:		Other Phone:	
E-mail address:			
Employment Information			
Geographical Region(s) You Work In: <i>(Check all that apply)</i>			
<input type="checkbox"/> Vancouver Coast & Mountains		<input type="checkbox"/> BC Rockies	
<input type="checkbox"/> The Islands		<input type="checkbox"/> Cariboo Chilcotin	
<input type="checkbox"/> Thompson Okanagan		<input type="checkbox"/> Northern British Columbia	
Health Authority You Work For: <i>(Check all that apply)</i>			
<input type="checkbox"/> FHA		<input type="checkbox"/> NHA	
<input type="checkbox"/> VCHA		<input type="checkbox"/> PHSA	
<input type="checkbox"/> VIHA		<input type="checkbox"/> Other <i>(please specify)</i> : _____	
<input type="checkbox"/> IHA			
Employer #1:			
Position:			
Stream: <i>(Check one)</i>			
<input type="checkbox"/> Adult		<input type="checkbox"/> Pediatric	<input type="checkbox"/> Family
Practice Setting: <i>(Check one)</i>			
<input type="checkbox"/> Primary Care Provider - General		<input type="checkbox"/> Secondary Care Provider*	
<input type="checkbox"/> Primary Care Provider - Specialty		<input type="checkbox"/> Tertiary (Acute) Care Provider	
Employer #2:			
Position:			
Stream: <i>(Check one)</i>			
<input type="checkbox"/> Adult		<input type="checkbox"/> Pediatric	<input type="checkbox"/> Family
Practice Setting: <i>(Check one)</i>			
<input type="checkbox"/> Primary Care Provider - General		<input type="checkbox"/> Secondary Care Provider*	
<input type="checkbox"/> Primary Care Provider - Specialty		<input type="checkbox"/> Tertiary (Acute) Care Provider	

Please turn over...

NP Education

(Students, please list your educational institution(s) and expected month and year of graduation.)

- | | |
|--|--|
| <input type="checkbox"/> Diploma | <input type="checkbox"/> Doctorate |
| <input type="checkbox"/> Baccalaureate | <input type="checkbox"/> Student |
| <input type="checkbox"/> Masters | <input type="checkbox"/> Other (please specify): _____ |

NP Educational Institution(s):

Graduation (month and year):

Membership Type *(Check one)*

- Voting – Active (Must hold a full, provisional or non-practicing license as an NP) **\$200/year**
- Non-voting – Associate (RN/public interested in NP practice) **\$50/year**
- Non-voting – NP Student (Proof of student status or student ID required) **\$50/year**

Privacy & Confidentiality

Your privacy is important to us. We do not and will not share or sell your personal information with third parties without your prior written permission and consent.

Please be aware, we **do** share your e-mail address with BCNPA approved agencies (e.g. UBC Therapeutics Initiative, Do Bugs Need Drugs, etc.), **and** publish your employer work and contact information on the NP directory on our website to help the public find service in their area, and to assist NPs in finding one another.

Please check one:

- Yes. I understand the above and allow BCNPA to share my e-mail address with BCNPA approved agencies and organizations, and publish my employer work and contact information to the BCNPA directory.
- No thanks. Please do not share my e-mail address to other agencies or publish my employer work and contact information to the BCNPA directory.

Payment Information

Please include a personal cheque or money order for the appropriate sum in full and make it payable to **BCNPA**.

Mail your completed application form *and* payment to:

BCNPA
c/o 5368 Ivar Place
Burnaby, BC
V5G 2C5

Should you submit your application and payment after September 30 of the current year, BCNPA will pro-rate your membership fees. Please contact us at info@bcnpa.org should this apply to you.