Australian Black African Nurses Association (ABANA)
Membership Form

Personal Information

Full Name: _____
Date of Birth: //____
Gender: ☐ Male ☐ Female ☐ Other
Address: _____
City: _____ **State:** _____ **Postcode:** _____
Phone Number: _____
Email: _____
Nationality: _____
Country of Origin: _____

Professional Information

Nursing Qualification(s): _____
Current Employment Status: ☐ Employed ☐ Unemployed ☐ Student ☐ Retired
Place of Work/Institution: _____
Position/Title: _____
Years of Experience in Nursing: _____
Areas of Specialization (if any): _____
Are you registered with AHPRA? ☐ Yes ☐ No
AHPRA Registration Number (if applicable): _____

Membership Category (Please Select One)

☐ Full Membership (Registered Nurses & Midwives) – $XX per year
☐ Associate Membership (Student Nurses & Nursing Assistants) – $XX per year
☐ Affiliate Membership (Non-nursing professionals supporting ABANA's vision) – $XX per year

Interest and Involvement

Why do you want to join ABANA?

_____
Are you interested in volunteering or mentoring? ☐ Yes ☐ No
Skills or expertise you would like to contribute:

_____

Emergency Contact

Full Name: _____
Relationship: _____
Phone Number: _____

Declaration

I hereby declare that the information provided above is true and correct. I agree to abide by the rules and regulations of the **Australian Black African Nurses Association (ABANA)** and actively contribute to its mission and objectives.

Signature: _____ **Date: //____**

Payment Information

Membership Fee: $_____

$20 per annum, $10 for students
Payment Method: ☐ Bank Transfer ☐ PayPal ☐ Other
(Bank details and payment instructions will be provided upon submission of this form.)

Submission Instructions

Please email the completed form to **[ABANA Email Address]** or submit it in person at an ABANA event. For further inquiries, contact **[ABANA Contact Information].**

Thank you for your interest in joining the **Australian Black African Nurses Association (ABANA).** We look forward to welcoming you to our community!