



# NDICN Membership Form

## Personal Information

Fields with \* are required

First Name*	
Last Name*	
Password*	
Password Again*	
NZNO Member	<input type="checkbox"/> Yes <input type="checkbox"/> No
If NO, would you like information on the NZNO?	<input type="checkbox"/> Yes <input type="checkbox"/> No
NZNO Number	
Membership Type	<input type="checkbox"/> Associate <input type="checkbox"/> Full
Mailing Address	
Town / City	
Phone	
Email	
Your Areas of Interest	

## Professional Experience

(especially any relating to infection control)

<input type="checkbox"/> Long Term Care <input type="checkbox"/> Acute Surgical <input type="checkbox"/> Paediatric Theatres <input type="checkbox"/> Other	<input type="checkbox"/> Obstetric <input type="checkbox"/> Acute Medical <input type="checkbox"/> Psychiatric
Number of Beds in Facility	
Number of years in Infection Control	
Hours per week employed in Infection Control	

Send or Fax to **Membership Co-ordinator, Sally-Ann Grant, CNS - Infection Control.**  
**Nelson Marlborough District Health Board, Private Bag 18, Nelson 7010**  
 Fax: (03) 539 3519