



WOCN Membership Application

◆ Name and Business Contact Information

First Name	Last	Middle	Credentials (e.g., BSN RN CRRN)
Title			
Place of Employment			
Address			
City		State	ZIP
Phone	Fax	E-mail	
Recruited by			

◆ Home Address and Contact Information

Address		
Address		
City/State or Province/ZIP/Country		
Telephone	Fax	E-mail

Preferred Mailing Address Business Home (Please check one box to indicate where you prefer to receive your mail.)

WOC Nurse Referral Listing (Web site) Business Home Do Not Publish
Membership Directory Listing Business Home Do Not Publish

◆ Membership Categories, Payment, and Contribution Information

- Active (Must be RN or ET)\$110 Retired-Active\$65
- Associate (Open to non RN professionals)\$105 Retired-Associate\$65
- Student*\$65

*For full-time students who are studying to become a registered nurse, provide the name, city, and state of the school you are attending in the space below.

School name _____ City _____ State _____

Deductibility of Contributions: Consult your tax adviser for information about the deductibility of membership fees and contributions.

I would like to make the following contribution(s)

WOCN Scholarship Foundation \$ _____ WOCN Center for Clinical Investigation \$ _____

Please specify WOCN Society Region /or Affiliate Preference I want to belong to Region _____ or Affiliate _____

(See map key enclosed)

A small portion of your dues will be allocated to the selected region or affiliate.

Form of payment (in U.S. funds only)	
<input type="checkbox"/> Check (payable to Wound, Ostomy, and Continence Nurses Society) <input type="checkbox"/> MasterCard <input type="checkbox"/> VISA <input type="checkbox"/> AMEX	
Acct. # _____	Exp. date _____
Signature _____	
I authorize WOCN Society to charge the above-listed credit card an amount reasonably deemed by WOCN Society to be accurate and appropriate.	

Total Dues \$ _____

Contribution Amount \$ _____

Outside U.S. \$ _____

Additional \$25

TOTAL \$ _____

over please ⇨



Wound
Ostomy and
Continence
Nurses
Society



Member Profile

Nursing Education

- Graduated WOC/ET full scope nursing education program Date of graduation MONTH DAY YEAR

- Graduated WOC/ET specialty nursing program Date of graduation _____

Nursing Experience

- Number of years of nursing experience _____
- Number of years experience as a wound, ostomy, or continence nurse _____

Gender (optional) Female Male Birthdate (optional) _____

Certification (Check all that apply.)

- CWCN CWCN COCN CCCN Not Certified Other

Employment Setting (Check one that is most applicable.)

- Hospital University/school Physician's office Pharmacy/supplier
 Industry Integrated system Home health system Outpatient facility
 Private practice Nursing home/Extended care facility Other

Practice Setting (Check all that apply.)

- Acute care Home care Outpatient care Extended care
 Education Administration Research Other

Areas of Practice (Check all that apply.)

- Wound and skin Ostomy Continent diversion Other
 Incontinence Behavioral therapies Skin care containment

Patient Population (Check all that apply.)

- Pediatrics Adult Geriatrics

Do You Accept Referrals? (Check all that apply.)

- No General information/Support only Outpatient Services

Please return your application and payment to WOCN:

WOCN

15000 Commerce Parkway

Suite C

Mt. Laurel, NJ 08054

Fax: (856) 439-0500

E-mail: wocn_info@wocn.org

www.wocn.org