**IMMUNISATION NURSES SPECIAL INTEREST GROUP**

 **MEMBERSHIP APPLICATION FORM**

NAME:

POSTAL ADDRESS:

EMAIL ADDRESS:

CONTACT TELEPHONE NUMBER:

◻ I wish to become a MEMBER of the Immunisation Nurses Special Interest Group (“the Association”). I am a Nurse Immuniser to whom the relevant Secretary Approval under regulation 161 of the *Drugs, Poisons and Controlled Substances Regulations 2017* (Vic) applies. I support the purposes of the Association. I agree to comply with the Rules of the Association.

OR

 ◻ I wish to become an ASSOCIATE MEMBER of the Immunisation Nurses Special Interest Group (“the Association”). I am NOT a Nurse Immuniser and I have an interest in the practice of immunisation. I support the purposes of the Association. I agree to comply with the Rules of the Association.

***INVOICE TO FOLLOW***

SIGNATURE:

NAME:

DATE: