WOCN® Society Member Application

◆ Name and Home Contact Information *(Required)*

First Name | Last Name | Birthday (optional)

Email Address (this will be your username) | Password

Home Address (required)

City | State or Province | Zip | Country

Phone | Fax

◆ Business Address and Contact Information

Business Name

Business Address

City | State or Province | Zip | Country

Phone | Fax | Email

◆ Membership Type (For a full description of all member types, please visit www.wocn.org)

◇ Full *(must be a WOC nurse)* $170

◇ Allied *(open to all other non-WOC nursing professionals)* $75

◇ Retired $65

◇ Student* $65

* For full-time students who are studying to become a registered nurse (includes those pursuing an Associate Degree, Bachelor of Science Degree, or Diploma Program) or those attending an accredited WOC Nursing Educational Program (WOCNEP). Please provide the name, city, and state of the school you are attending in the space below. Student membership valid for one year only, per individual.

School Name ____ City ____________________ State __________

I would like to make the following contribution:
WOCN Scholarship Foundation $________

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

Please specify which Region or Affiliate you would like to belong to: ______________________________
(for Region or Affiliate map visit www.wocn.org) *A small portion of your dues will be allocated to the selected Region or Affiliate.*

Form of payment (in U.S. funds only)

☐ Check (payable to Wound, Ostomy, and Continence Nurses Society)

☐ MasterCard ☐ VISA ☐ AMEX

Acct. # ______________________________ Exp. date __________________

Signature ____

I authorize the WOCN Society to charge the above-listed credit card an amount reasonably deemed by the WOCN Society to be accurate and appropriate.

Total Dues $______
Contribution Amount $______
TOTAL $______

Tax ID#: 25-1251887

over please ⇨

Member Profile

Gender ◇ Female ◇ Male

Age Range ◇ 21-35 ◇ 36-45 ◇ 46-55 ◇ 56-75 ◇ 76 and up

Certifications *(check all that apply)*

◇ CWOCN ◇ CWCN ◇ COCN ◇ CCCN ◇ CWON ◇ CWOCN-AP ◇ CWCN-AP
◇ COCN-AP ◇ CCCN-AP ◇ CWON-AP ◇ CNS ◇ CFCN ◇ ANP-BC ◇ FNP-BC
◇ PNP-BC ◇ CWS ◇ CWCA ◇ WCC ◇ None ◇ Other ______________

Education Levels *(check all that apply)*

◇ ADN ◇ BS ◇ BSN ◇ MS ◇ ANP ◇ None
◇ PNP ◇ PhD ◇ DNP ◇ MSN ◇ FNP ◇ Other ______________

Areas of Practice *(check all that apply)*

◇ Continence ◇ Incontinence: Behavioral Therapy ◇ Incontinence
◇ Incontinence: Skin Care/Containment ◇ Ostomy ◇ Wound/Skin
◇ Foot and Nail Care ◇ None ◇ Other ______________

Patient Populations *(check all that apply)*

◇ Adult ◇ Geriatrics ◇ Pediatrics ◇ Bariatrics ◇ None ◇ Other ______________

Employment Setting *(check all that apply)*

◇ Home Health Care ◇ Hospital-Acute Care ◇ Hospital-Long Term Acute Care
◇ Industry ◇ Nursing Home ◇ Out-Patient Clinic
◇ Pharmacy ◇ Physician Office ◇ None
◇ University/School ◇ Hospice ◇ Other ______________
◇ Private Practice

Role Functions *(check all that apply)*

◇ Direct Patient Care ◇ Staff Development ◇ Research ◇ Consultation
◇ Administration/Supervision ◇ Education ◇ None ◇ Other ______________

Licensure *(check all that apply)*

◇ RN ◇ APRN ◇ LPN/LVN ◇ MD ◇ RPT ◇ None ◇ Other ______________

Memberships to Other Organizations *(check all that apply)*

◇ ANA ◇ Sigma Theta Tau ◇ Oncology Nurses ◇ NAWC ◇ None
◇ CAET ◇ SUNA ◇ DNA ◇ WCET ◇ Other ______________

Would you like to be included in our Nurse Referral Database?

◇ Yes ◇ No

Would you like to be included in our Preceptor Database?

◇ Yes ◇ No

Please return your application and payment to the WOCN Society:

WOCN Society • 1120 Route 73, Suite 200 • Mt. Laurel, NJ 08054
Fax: (856) 439-0525 • www.wocn.org