

BARBADOS OVERSEAS NURSES ASSOCIATION

APPLICATION FORM

NAME: _____

ADDRESS: _____

TEL NO: _____

DAY & MONTH
OF BIRTH: _____

PLACE OF WORK: _____

ARE YOU RETIRED?*: _____

* If yes, please state
your last place of work _____

Please tick the appropriate the box
Are you

- Registered Nurse
- Registered Midwife
- Healthcare Assistant

SIGNATURE: _____ DATE: _____

Please return completed form to the Secretary:

Barbados Overseas Nurses Association
P.O. Box 479
Croydon
CR9 6ZN

Office Use Only

Date of Joining

Fee enclosed

Annual Subscription £20.00 per year