HAWAI'I ASSOCIATION
FOR WOUND, OSTOMY AND CONTINENCE CARE

www.HawaiiAssocWOCC.org

MEMBERSHIP APPLICATION

Please complete the information requested below:

Name: _____

Professional Category: *(Ex: MD, NP, PA, RN, LPN, PT, PTA, OT, Pharmacist, Dietitian, etc.)*

_____

Employer:_____ **Position:**_____

Address:_____

City:_____ **State:**_____ **Zip Code:** _____

Email:_____ **Phone:** _____

Please indicate the type of membership: **Annual dues to be collected on anniversary month**

Individual Membership:

□ **Clinician/Individual (non WOCN)**…….. *$50.00*
□ **Clinician/ Individual (with WOCN membership)** …….. *$35.00*
□ **Retiree**…….. *$35.00*
□ **Student (undergraduate)**…… *$40.00*
□ **Honorary**…….. *$ 0.00*

Facility/Corporate/Manufacturer: *(Covers the cost of one representative)*

□ **Clinic/Hospital/Healthcare Facility**…… *$100.00*
□ **Manufacturer/Corporation:**

Total: ☐

Name of company/Facility: _____

Address: _____

City:_____ **State:**_____ **Zip:**_____

Email:_____ **Phone:**_____

☐ *Checkbox if you* **do not** *wish to share your email address with vendors*

Note: *Video and/or photography documentation may take place during conferences/meetings. HAWOCC reserves the right to use all photos and videos taken during the conference for promotional purposes. Please advise a the photographer if you do not wish to be photographed at that time.*

Payment Method: *Check/Money order (payable* **to Hawaii Assoc. for WOCC***)*
Send to: *Katie Steinhelfer, 2011 Waiola Street, Honolulu, HI 96826*