WORKPLACE REPRESENTATIVE

REGISTRATION FORM

Date: ____________

Name: ____________________________ Registration No.___________

Mailing address where you want information sent to:

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Work email Address: ______________________________________

or Home email Address:______________________________________

Work phone number for contact: _________________

Place of Employment: _________________________________

Health Region: _______________________________________

Position: ____

For planning purposes please state how many RNs and RN(NP)s you will share SRNA information with?_________________________

Please inform us of any changes to the above information* or *if you no longer wish to be involved with the program.

By joining the program the individual agrees to:

- Be a communication person for RNs or RN(NP)s in their work area and the SRNA.
- The Representative agrees to share information with RN or RN(NP) colleagues that is received by email or by mail (mail outs are about 4 times per year). The information will be on nursing, healthcare, education workshops or conferences, and various health and social issues that pertain to nursing. Please inform us of any information you would like to see in the mail out packages.
- If desired, representatives can liaise with Workplace Representatives in their health region or work facility during National Nursing Week or for other celebratory events to share resources and plan events.
- As needed, assist Graduate Nurses, Internationally Educated Nurses or newly relocated nurses on how to access SRNA resources or staff.

The SRNA adheres to PIPEDA and privacy legislation. We do not share personal information including your home contact information without your permission. Under privacy laws your name, work contact address, work telephone number or work email address are public information. Only this information can be shared as requested.

Please read and sign if you agree*:*

As a participant in this program I agree to the criteria required for being apart of the SRNA Workplace Representative Program and to share my name, work phone number, email address or work location (please circle your preference for contact) with other Workplace Representative, SRNA members or others involved in healthcare service delivery.

Name________________________ *Date_______________________*

The SRNA will provide you with funds to purchase a small bulletin board for your workplace if you wish to post the information. Contact us if you would like a bulletin board.

Email completed forms to Debbie Cummings
or Fax 306-359-0257