



# ONTARIO OCCUPATIONAL HEALTH NURSES ASSOCIATION

Suite 605, 302 The East Mall, Toronto, Ontario M9B 6C7

Tel: 416-239-6462 Fax: 416-239-5462 www.oozna.on.ca

## APPLICATION / RENEWAL FORM FOR 2010

The following information reflects our current records.

Please review the information carefully. Make any changes directly on the form and return with your payment

Name \_\_\_\_\_ Home Address \_\_\_\_\_

Title \_\_\_\_\_ City/Prov \_\_\_\_\_ Tel: \_\_\_\_\_

Company \_\_\_\_\_ Postal Code \_\_\_\_\_

Address \_\_\_\_\_ Email \_\_\_\_\_

City/Prov \_\_\_\_\_ Date of Birth \_\_\_\_\_

Postal Code \_\_\_\_\_ Nursing Registration Number \_\_\_\_\_

Tel \_\_\_\_\_ Ext \_\_\_\_\_ Fax \_\_\_\_\_ RNAO Registration Number \_\_\_\_\_

Email: \_\_\_\_\_ Send Mail to Work Address: \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you belong to a Local Area Association? \_\_\_\_\_  
If yes, identify: \_\_\_\_\_

### EMPLOYMENT POSITION

Identify the most appropriate information for your current position.

P = Primary Function (Indicate one only)

S = Secondary (Check those which apply)

- Provides direct/primary care for employees \_\_\_\_\_
- Administers Employee Benefits \_\_\_\_\_
- Administers Workers' Compensation \_\_\_\_\_
- Provides Consultation Services to Multiple Co's \_\_\_\_\_
- Develops and implements wellness programs \_\_\_\_\_
- Manages Occupational Health Services \_\_\_\_\_
- Lecturer/Educator \_\_\_\_\_
- Case Management \_\_\_\_\_

### DO YOU WORK FOR MORE THAN ONE COMPANY

Yes \_\_\_\_\_  
No \_\_\_\_\_

### ARE YOU A SELF-EMPLOYED CONSULTANT?

### HOW IS YOUR POSITION CLASSIFIED?

Management \_\_\_\_\_  
Non-Management \_\_\_\_\_

### INDICATE YOUR EMPLOYER TYPE

- |                                |                        |
|--------------------------------|------------------------|
| Communications _____           | Manufacturing _____    |
| Construction _____             | Mining/Smelting _____  |
| Contract Services _____        | Print/Publishing _____ |
| Education _____                | Pulp & Paper _____     |
| Finance _____                  | Registry/Agency _____  |
| Food/Beverage _____            | Rehabilitation _____   |
| Government _____               | Retail/Wholesale _____ |
| Hospital/Health Facility _____ | Transportation _____   |
| Independent Practice _____     | Utilities _____        |
| Insurance _____                |                        |

Other (please specify) \_\_\_\_\_

NEW MEMBER? \_\_\_\_\_ Yes \_\_\_\_\_ No

### Who Referred you to OOHNA?

\_\_\_\_\_

### EMPLOYMENT STATUS

- Full Time Nursing \_\_\_\_\_
- Part Time Nursing \_\_\_\_\_
- Not Employed in Nursing \_\_\_\_\_

### Number of Years in:

- Occupational Health Nursing \_\_\_\_\_
- Present Employment \_\_\_\_\_

### POST SECONDARY EDUCATION

Indicate level attained

### Nursing Education Yes/No

- Diploma \_\_\_\_\_
- Specialty Certificate/Diploma \_\_\_\_\_
- Baccalaureate \_\_\_\_\_
- Masters \_\_\_\_\_
- Doctorate \_\_\_\_\_

### Occupational Health Education Yes/No

- Certificate (Community College) \_\_\_\_\_
- Diploma (University) \_\_\_\_\_
- C.O.H.N.(C) \_\_\_\_\_
- C.O.H.N.-S \_\_\_\_\_
- C.R.S.P. \_\_\_\_\_
- Other \_\_\_\_\_

### Non-Nursing Education Yes/No

- Specialty Certificate/Diploma \_\_\_\_\_
- Baccalaureate \_\_\_\_\_
- Masters \_\_\_\_\_
- Doctorate \_\_\_\_\_

### SUBSTANCES IN YOUR WORKPLACE

- |                      |               |
|----------------------|---------------|
| Acrylonitrile _____  | Mercury _____ |
| Asbestos _____       | Noise _____   |
| Benzene _____        | PCB's _____   |
| Coal tar pitch _____ | Silica _____  |
| Isocyanates _____    | Lead _____    |

Other Substances \_\_\_\_\_

### PROGRAMS AT YOUR WORKPLACE

- |                                    |        |
|------------------------------------|--------|
|                                    | Yes/No |
| Back Care _____                    | _____  |
| Disability/Case Management _____   | _____  |
| Employee Assistance Program _____  | _____  |
| Environmental Compliance/Law _____ | _____  |
| Ergonomic Programs _____           | _____  |
| Hazard Awareness _____             | _____  |
| Health Screening _____             | _____  |
| Hypertension _____                 | _____  |
| Infection Control _____            | _____  |
| Modified Work/Rehabilitation _____ | _____  |
| Physical Demands Analysis _____    | _____  |
| Respiratory Equipment _____        | _____  |
| WHMIS _____                        | _____  |

### DO YOU HAVE Yes/No

- Medical Directives \_\_\_\_\_
- Job Description \_\_\_\_\_
- Policy & Procedure Manual \_\_\_\_\_
- A Physician – Full Time \_\_\_\_\_
- A Physician – Part Time \_\_\_\_\_
- Administration of Budget \_\_\_\_\_

### ARE YOU WILLING TO SERVE ON A TASK FORCE OR SHORT TERM COMMITTEE?

Yes \_\_\_\_\_ No \_\_\_\_\_

### ARE WILLING TO SHARE YOUR RESEARCH TOPICS?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list topics:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### WOULD YOU BE WILLING TO SHARE YOUR E-MAIL ADDRESS WITH OOHNA MEMBERS ?

Yes \_\_\_\_\_ No \_\_\_\_\_

Email Address: \_\_\_\_\_

# MEMBERSHIP CATEGORIES & PAYMENT INFORMATION

## 1. Regular Members

Each applicant for regular membership shall be:

1. A Registered Nurse holding a current Certificate of Competence under the Regulated Health Professions Act, or under any successor act who;
2. Practices occupational health nursing in Ontario, or resides in Ontario and practices occupational health nursing elsewhere; or
3. Is a member who so ceases to qualify but retains full membership to end of the calendar year, unless the member's license is revoked.

**Note: Professional Liability Insurance and Legal Expense coverage is inclusive for all regular members.**

## 2. Retired Members

Each applicant for retired membership shall be:

1. A full member of the Association for the five years immediately preceding the initial application for retired membership in the Association or
2. Permanently retired from active employment in nursing.

**Note: Professional Liability Insurance coverage is recommended after retiring. Contact the OOHNA office for more information.**

## 3. Associate Members

Each applicant for associate membership shall be:

1. A Registered Nurse holding a current Certificate of Competence under the Regulated Health Professions Act, or any successor act, who is interested in occupational health nursing and has not been employed in occupational health nursing in Ontario in the past 12 months.
2. An occupational health nurse registered as a nurse in another Canadian province or territory who, if an Ontario resident, would be eligible for registration with the College of Nurses of Ontario; or
3. A registered nurse not employed in nursing, but interested in occupational health nursing.

**Note 1: No person who is eligible for Regular Membership in the Association shall be accepted as an Associate Member.**

**Note 2: Should your status change (Regular, Retired or Associate), the Association MUST be notified in writing.**

## APPLICATION FOR MEMBERSHIP

Application for membership shall be accompanied by payment of the applicable annual membership fee, which shall be returned to the applicant if membership is refused or the application is incomplete.

### MEMBERSHIP FEE

**PLEASE CHECK APPROPRIATE CATEGORY – IF PAYING BY CREDIT CARD PLEASE ADD \$10.00 TO AMOUNT DUE**

**Note: Includes GST/HST - GST/HST # 10400 1318**      **AMOUNT DUE**

- |  |                 |
|--|-----------------|
| <input type="checkbox"/> RENEWAL Dec 31 2009– Dec 30 2010(Deadline Dec 24/09)            |                 |
| <input type="checkbox"/> Regular Member - With Insurance (includes \$6.75 GST)           | <b>\$395.55</b> |
| <input type="checkbox"/> Associate Member - No Insurance (includes \$6.75 GST)           | <b>\$141.75</b> |
| <input type="checkbox"/> Retired Member - No Insurance (includes \$2.50 GST)             | <b>\$ 52.50</b> |
| <input type="checkbox"/> Assoc. out of Prov. – With Full Insurance (includes \$6.75 GST) | <b>\$395.55</b> |

### NEW / LAPSED MEMBER Jan 01 2010– Dec 30 2010

- |  |                 |
|--|-----------------|
| <input type="checkbox"/> Regular Member - With Insurance (includes \$8.00 GST) | <b>\$421.80</b> |
| <input type="checkbox"/> Associate Member - No Insurance (includes \$8.00 GST) | <b>\$168.00</b> |

### HALF YEAR MEMBERSHIP From July 01 2010– Dec 30 2010

- |   |                 |
|---|-----------------|
| <input type="checkbox"/> Regular Member - With Insurance (includes \$13.00 HST) | <b>\$239.90</b> |
| <input type="checkbox"/> Associate Member - No Insurance (includes \$ 9.75 HST) | <b>\$113.00</b> |

**Permanently Retired Members can apply for coverage for past incidences only. Please contact the OOHNA office before December 5<sup>th</sup> to obtain application forms.**

**Cheques Returned NSF are subject to \$16.95 service charge.**

### SIGN & COMPLETE BEFORE YOU MAIL

#### HAVE YOU ENCLOSED?

- Please write your Current Registration number from the College of Nurses of Ontario.

**NOTE: Out-of-province members must provide a current nursing license from the province of residence**

REGISTRATION # \_\_\_\_\_

- Insurance Application Form (NEW MEMBERS & LATE RENEWALS)
- Cheque or money order for the AMOUNT DUE made payable to the Ontario Occupational Health Nurses Association (If GST exempt, an exemption form must accompany the application) **IF PAYING BY CREDIT CARD PLEASE ADD \$10.00 to AMOUNT DUE.**

- Current email address: \_\_\_\_\_
- This certifies that I am currently registered as an RN with the College of Nurses of Ontario and that all of the above information is accurate.

Signature \_\_\_\_\_

Date \_\_\_\_\_

By renewing your membership in the Ontario Occupational Health Nurses Association (OOHNA) and submitting the above information for consideration, you agree to abide by the code of ethics, and bylaws of the association, submit accurate information and understand that it is a breach of the association's code of ethics to provide false information. You also understand that you must pay annual dues to maintain membership in OOHNA and that OOHNA may release information to certain partners/approved groups from time to time as required. OOHNA is committed to protecting the privacy of your personal information. Information collected from this form will be used for renewal purposes, and to notify you about OOHNA programs and services. For more information please visit our website at [www.oohna.on.ca](http://www.oohna.on.ca)

#### FOR OFFICE USE ONLY

PAID BY:  Company Cheque     Self

Master Card     VISA

Amount: \$ \_\_\_\_\_

Date Received: \_\_\_\_\_

#### METHOD OF PAYMENT – PLEASE COMPLETE

PAID BY:     Company Cheque     Self     Master Card     VISA

AMOUNT DUE: \$ \_\_\_\_\_ (Amount Due **MUST include \$10.00** fee if paying by Credit Card and will be applied if not included)

Master Card/VISA No.

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CVC Code – last 3 digits on back of card

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Expiry Date

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Month/Year

Signature (for Credit Card) \_\_\_\_\_

Print Name of Card Holder \_\_\_\_\_

Today's Date (DD/MM/YY) \_\_\_\_/\_\_\_\_/\_\_\_\_



## APPLICATION FOR PROFESSIONAL LIABILITY & LEGAL EXPENSE INSURANCE

If insufficient space for any reply, please attach paper

**Coverage only applies to individual OOHNA members (not corporation, partnerships, etc).**

1. Name of Applicant \_\_\_\_\_ Daytime Phone No. \_\_\_\_\_  
Address of Applicant \_\_\_\_\_
  
2. Name of Current Employer \_\_\_\_\_ Phone No. \_\_\_\_\_  
Address of Current Employer \_\_\_\_\_
  
3. Do you hold a current nursing license with the province of your residence?  Yes  No  
Which province? \_\_\_\_\_
  
4. Date you qualified as a registered nurse? \_\_\_\_\_  
Do you have an occupational health nursing certificate or diploma?  Yes  No
  
5. Have you ever been disciplined by any licensing body? (i.e. College of Nurses of Ontario)  Yes  No  
If yes, please give details \_\_\_\_\_
  
6. Have you ever been the subject of any criminal action as a result of your profession?  Yes  No  
If yes, please give details \_\_\_\_\_
  
7. Were you insured previously for professional liability other than under this program?  Yes  No  
Name of Insurer \_\_\_\_\_ Policy Period \_\_\_\_\_ Limit \$ \_\_\_\_\_
  
8. Have you ever had similar insurance declined, cancelled or the renewal refused?  Yes  No  
If yes, please give details \_\_\_\_\_
  
9. Have you even been the recipient of any allegation(s) of professional negligence either in writing or verbally?  Yes  No  
If yes, please give details \_\_\_\_\_
  
10. Have you any knowledge or information of any negligent act, error, or omission or breach of duty, which might give rise to a claim against you, or any reason to anticipate that a claim might be brought against you?  Yes  No  
If yes, please give details \_\_\_\_\_
  
11. If self- employed, describe your operation and attach any brochures (if available).

This insurance is written on a claims made and reported basis which means that the policy will only apply to those claims made against the applicant during the policy period and reported to the insurance company during the policy period.



The acquisition of knowledge in the policy period of circumstances that may give rise to a claim in the future must also be reported to the insurance company during the policy period in order for coverage to apply to a future claim that arises out of those circumstances.

This application does not bind the applicant or the insurance company to complete the insurance, but it is agreed that this form shall be the basis of the contract should a policy be issued, and it will be attached to and made a part of the policy. The Applicant agrees that if the information supplied on the application changes between the date of the application and the time when the policy is issued, the applicant will immediately notify the insurance company of such change.

**SIGNATURE**

I declare that to the best of my knowledge the statements set forth herein are true. It is agreed that this completed and signed application shall be the basis of the insurance contract to be issued.

I may have provided personal information in this document and by other means and I may in the future provide further personal information. Some of this personal information may include, but is not limited to, my credit information and claims history. I authorize my broker or insurance company to collect, use and disclose any of this personal information, subject to the law and to my broker's or insurance company's policy regarding personal information, for the purposes of communicating with me, assessing my application for insurance and underwriting my policies, evaluation claims, detecting and preventing fraud, and analyzing business results. I confirm that all individuals whose personal information is contained in this document have authorized that I agree to the above on their behalf.

Signature of Applicant \_\_\_\_\_

Date \_\_\_\_\_

Please forward this completed application form, along with a cheque and membership to OOHNA.