



**Section 1** Section 1 & 2 of this application form must be completed.

**Full Name:** \_\_\_\_\_  
 (Block Capitals) (State whether Mrs. Ms or Mr)

**Postal Address:** \_\_\_\_\_  
 (Block Capitals) \_\_\_\_\_  
 \_\_\_\_\_

**Mobile Phone:** \_\_\_\_\_

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

**Place of Employment:** \_\_\_\_\_

**Payroll/Staff No.** \_\_\_\_\_  
 (available on pay slip)

**FOR REGISTERED NURSES ONLY**

Position held at present \_\_\_\_\_

An Bord Altranais Pin Number IN:

General training \_\_\_\_\_ R.N.I.D \_\_\_\_\_

Midwifery \_\_\_\_\_ Psychiatry \_\_\_\_\_

Public Health \_\_\_\_\_ Sick Children's \_\_\_\_\_

**Date of Birth** Day   Month   Year

**In order to cover your membership until deductions commence a remittance by personal cheque, postal order or banker's draft for €76.50 (or €57.00 if working in a Private Nursing Home) made payable to INMO should be included when returning your application. If you wish to make this payment by Credit Card or Laser please print, complete and return the form below. This will cover the first three months of your membership after which deductions will commence either from your salary (authorization form below) or your bank (form found on Membership home page at [www.inmo.ie](http://www.inmo.ie).)**

<b>FOR OFFICE USE ONLY</b>	
Membership No.	_____
Amount Paid	_____
Date	_____

**Section 2**

State if member of another organisation / union, or if previously a member of any organisation / union:

\_\_\_\_\_

The name of such organisation / union:

\_\_\_\_\_

Date membership of organisation/union ceased: \_\_\_\_\_

If formerly a member of I.N.MO, state:

Membership Number:  
(if available) \_\_\_\_\_

Year of Lapsing: \_\_\_\_\_

Signature: \_\_\_\_\_

**AUTHORISATION TO DEDUCT  
INO MEMBERSHIP FEE FROM PAY**

Name: \_\_\_\_\_

(Block Capitals Please)

Employed at \_\_\_\_\_

Authorise the deduction from my pay, until further notice the sum of €25.50 per month in respect of the Irish Nurses & Midwives Organisation financial year, January - December, to be deducted on each pay day and paid to the Organisation on my behalf. I also agree that if the subscription be varied, the deduction shall be varied accordingly. If there is an inadvertent shortfall in the amount deducted at source in respect of annual fee, I agree to pay the balance direct to the Organisation.

INO No: \_\_\_\_\_

Payroll/Staff No. \_\_\_\_\_  
(available on pay slip)

Signature: \_\_\_\_\_

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

**ON COMPLETION OF THIS FORM PLEASE RETURN IT DIRECTLY**

**Irish Nurses & Midwives Organisation**  
**The Whitworth Building,**  
**North Brunswick Street,**  
**Dublin 7.**

