OFPN NEWSLETTER

FALL 2010

ONTARIO FAMILY PRACTICE NURSES

"To promote and support the professional role of the Registered Nurse in family practice."

INSIDE THIS ISSUE:

PRESIDENT'S MESSAGE

As fall pushes on, the Executive and the Conference Committee have recovered from the excitement and stress of the most successful conference yet. Several important decisions were made at the Biennial Meeting, which I'd like to outline for you here.

We increased our dues to $60. We have not had an increase in dues in many years, and expenses will be going up because of the Harmonized Sales Tax. This new $60 fee will include membership in the Canadian Family Practice Nurses Association. See the membership report for more details

We have changed the structure of the OFPN Board somewhat to meet the changing face of family practice nursing. The growth of numbers of nurses in Family Practice, especially in the Family Health Teams, has highlighted the uncertainties about nursing roles and professional issues. To deal with this we have created a position of Professional Practice Director. There are many professional practice issues for FP nurses such as roles of nurses, working with medical directives, responding to requests to participate in research, helping with preceptorship for the George Brown College course, and on and on.

We have expanded the newsletter editor position to that of Communications Director. This will include producing the newsletter, as well as development and management of our website, and any other communication vehicles.

We have created a Member at Large position, which allows former executive members to continue to participate in running the organization, and also can serve as an orientation position for new executive members.

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OFPN EXECUTIVE 2010-2011

(Continued from page 1)

In the past the President or delegate from each Chapter also sat on the executive. Because many of the Chapters are inactive at present, and some areas of the province do not have a Chapter, we changed this to regional representatives. We hope that in regions with inactive or no chapters someone will come forward as the voice for that region.

As President of OFPN I was invited to participate in the Ontario College of Family Physician's "Vision 2020" Day. OCFP brought together a group of Family Physicians from urban and rural areas, staff from the Ministry of Health and Long Term Care and from the LHINs, staff from Ontario Medical Association, and politicians to talk about the challenges facing family physicians and their patients in the next decade. There was a lot of discussion about Electronic Health Records, scope of practice, changing technology and changing patient expectations. A facilitator helped pull the themes together, and identify the major challenges that OCFP needs to be prepared to address in the next ten years.

Also as your President I represent OFPN at the RNAO Interest Group chairs meeting twice a year, as well as the RNAO Assembly meeting three times a year. The IG chairs meeting is particularly interesting as we hear about the challenges and successes from other Interest Groups and realize we are all struggling with the same issues.

And finally, I heard recently that the George Brown Family Practice Nursing course has finally been approved to go ahead. You will find further details elsewhere in the newsletter.

I hope nurses will volunteer to be an active part of our organization. We need people to be part of the Professional Practice Committee. We need nurses to come forward to represent their regions. We used to have Chapters in Toronto, Wellington County and Simcoe County, but they died for lack of manpower.

We are also hoping to publish articles from members in the newsletter. The article from Jennifer Hartman in this issue is an example we hope others will follow.

Have a great year, and stay tuned to all the great developments in OFPN.

Judie Surridge, RN
President
Ontario Family Practice Nurses

ADVOCATE FOR YOUR ROLE!

TO BECOME INVOLVED IN THE PROFESSIONAL PRACTICE COMMITTEE, PLEASE CONTACT ALICIA ASHTON

LET'S HEAR YOUR VOICES, OFPN

YOUR NEW EXECUTIVE COMMITTEE WANTS YOU TO BECOME INVOLVED.

PLEASE SEND US SUBMISSIONS FOR THE QUARTERLY NEWSLETTERS.

SUBMISSIONS CAN INCLUDE AN ARTICLE, TOPIC SUGGESTIONS, RECOMMENDED READING, SHARING CLINICAL SUCCESSES, LETTERS TO THE EDITOR., ETC.

SUBMIT TO: kelly.pensom@wchospital.ca

MEMBERSHIP UPDATES

Since the formation of the Canadian Family Practice Nurses Association (CFPNA) there has been a lot of confusion among members, in that some members were under the misunderstanding that membership to OFPN meant automatic membership to the CFPNA. Or that membership to the CNA, (Canadian Nurses Association) meant automatic membership to CFPNA.

After discussion at the biennial general meeting in May of this year it was agreed by vote that membership to OFPN and CFPNA will be combined. The new membership fee will be $60 annually. This reflects an increase of $10, since OFPN membership was $30 and CFPNA membership was $20. Having a combined provincial and national membership will give members more opportunities for networking and also present a more united front. OFPN and CFPNA continue to develop an on-going collaborative relationship with RNAO, the Canadian Nurses Association (CNA) as well as the Ontario College of Family Physicians (OCFP) and the Canadian College of Family Physicians(CCFP). For more information about CFPNA, please check their website at www.cfpna.ca

In some areas of Ontario there are active groups (Chapters) who meet regularly to offer support and networking opportunities on a local level. If you are interested in joining one of the groups identified on our registration form, please complete the form and send it to me. Unfortunately several Chapters are no longer active due to leadership burnout. The OFPN executive are looking for people who would be willing to represent their region by email or telephone conference, thus providing input on the needs of members in their region.

For those of you who do not pay your OFPN membership fees through RNAO, you must mail in the form with a cheque for $60 made out to Ontario Family Practice Nurses. The registration form is contained in this newsletter and is available on the OFPN page of the RNAO website (www.rnao.org).

Over the last year we have been sending information about professional and educational opportunities to our members by email. Unfortunately there are a number of emails that do not go through despite thorough review. Please make sure you PRINT your email address clearly as we will be sending most of our information by email in the future. Also if you use a firewall please make sure that it recognizes OFPN as we will use that in our subject line.

Barb Thompson, RN, OFPN Membership Chair

MEMBERSHIP FORMS

Must be filled in by all members, whether joining through RNAO or not.

Please make sure to CLEARLY update your email address with the Membership Chair if you have not already done so.

PROPOSED CHANGE TO THE NEWSLETTER

PLEASE EMAIL OFPN COMMUNICATIONS BY MARCH 1, 2011 WITH ANY QUESTIONS OR OPPOSITIONS TO THE PROPOSED RECOMMENDATION:

We would like to propose a paperless newsletter, which can be easily accessed by members on the OFPN website via RNAO. Members will be emailed with newsletter updates. Email newsletter updates will be considered the default for future memberships.

If you prefer to receive a hard print copy of the newsletter, it must be requested on future membership forms, or please email me and I will happily send you one.

This is one way OFPN can help the environment!

Kelly Pensom, RN,
Communications Officer
kelly.pensom@wchospital.ca

A PRIMARY CARE NURSES' PERSPECTIVE ON ONTARIO'S PHYSICIANS ASSISTANT INITIATIVE

Kelly Pensom, RN, BScN & Judie Surridge, RN

There is a new, unregulated worker on the scene in health care. It is the Physician Assistant (PA). "A PA is an unregulated health-care provider who, under the supervision and delegation of a physician, can perform such acts as to: take client histories, conduct physical examinations, write orders, interpret test results, diagnose and treat illness, counsel on preventive health care, write prescriptions and assist during surgery."[1]

In the best interests of accessibility to health care for Ontarians, the MOHLTC suggests that this new role is intended to address the health human resources shortage and improve access and minimize wait times in high priority areas in Ontario.[2] In terms of access to health care, MOHLTC is recommending that PAs be utilized in high priority areas such as emergency departments, CHCs, some Family Health Teams and internal medicine positions in underserviced areas.[2] PAs are already involved in primary care in Ontario, such as in CHCs and FHTs[3], with the intention of improving access and reducing the number of unattached patients. What does this mean for RNs, RN(EC)s and RPNs working or interested in these fields at a time when we are eager to work to our fullest scopes of practice to meet those same goals? What will it mean for recruitment and retention of RNs, RN (EC)s and RPNs as CHCs and FHTs continue to roll out across the province?

RNAO has outlined a position statement regarding their concern for the PA initiative in Ontario, which can be accessed at www.rnao.org.[1] OFPN shares RNAO's concern with government support for this new category of worker on many levels:

OFPN is concerned with the training of PAs compared to RNs and RN(EC)s

In their position statement, RNAO compares and contrasts the educational requirements amongst military and civilian PAs, RNs and RN(EC)s.[1] While the respected role of the military PA requires significant years of training (12-15 years in service with medical assistance requirements) prior to initiating the PA program. Civilian PAs require only 2 years undergraduate education, in any field of study, prior to admission to a 2 year PA program, which allows PAs to work as physician extenders, practicing medicine under MD supervision.[4] RNAO further contrasts this to the required training and education of RNs and RN(EC)s to work within their respective scopes: 4 years of undergraduate study, either entirely in nursing or 2 years in another field of study with particular requirements for RNs to practice within the regular class scope of practice; and a minimum of 2 years of professional practice plus another 2 years of study for an RN (EC). Add to this the projected requirement for RN(EC) s to attain a Master of Science in Nursing prior to initiating an NP program in the future.

OFPN is concerned with the financial implications of the Ontario PA initiative.

In a recent initiative to hire new PA graduates by October 31, 2010, the government has provided grants of between $46,000-$92,000 to eligible employers who hire PA graduates for at least 2 years.[2] The level of the grant is determined by clinical setting and geography[2,5]: $92,000 for CHCs and FHTs.[5] Eligible employers are able to receive this grant for 2 years. From these grants, eligible employers are required to pay the *new graduate* PA a *minimum* salary of $75,000 plus benefits.[2,5] In the Canadian Medical Association's PA-Toolkit for physicians, The Canadian Association of Physician Assistants (CAOPA) recommends that this salary range upwards to $130,000 in Ontario.[6] An additional $10,000 grant incentive was offered in Ontario this year to physicians willing to supervise a PA.[5] It is unclear whether these grants were only for this year, or if they will be offered in subsequent years as more PAs graduate.

As far as OFPN is aware, there are no incentives to employers in CHCs or FHTs who hire nurses, and the unjust discrepancies in pay parity are clear. According to the Family Health Team Guide for Interdisciplinary Provider Compensation from the MOHLTC, the recom-

mended salary for RNs is $55,251-$66,568.[7] The RN (EC) recommended salary is $78,054-$89,203.[7] Benefits plans for these interdisciplinary professionals is only funded by the MOHLTC in the event that a FHT's application approval allows for the hiring of full-time and salaried positions, versus part-time positions.[7]

Currently, cutbacks are an issue, with nursing at the eye of the storm once again. If nurses are being laid off, or having difficulty finding work, even in the high priority areas articulated by the PA initiative, it makes one wonder if some funding for nursing in Ontario is being siphoned into the PA initiative.

How will using higher paid professionals be optimal for MOHLTC budgets? There is little Canadian evidence with regard to this. CAOPA suggests that the 'business case' for PAs is well documented, yet all but one reference to their case comes from US studies, with one as outdated as 1974.[6] Canada cannot continue to strive for a sustainable health care system by looking to an evidently *unsustainable* example for evidence.

Add to the funding strain the idea that the CMA and the OMA recommend that the billing fee schedule be adjusted so that MDs are compensated for the care PAs provide under MD 'supervision'; even indirect, supervision when the MD is not present.[5,8] It is unclear in OMA's statement on working with PAs, or the CMA PA-Toolkit, whether the intention for this proposed billing is to contribute to the PA salary or not.

Will this PA initiative truly provide an economically sustainable resolution to health care access issues? Do nurses not represent a more economically viable option? Our salaries are lower, though arguably could be increased. Nurses have the knowledge, skill and judgment to safely, effectively and economically provide many of the services outlined by PAs as their role[4] within our scope of practice, or under medical directives, or with special training certifications.

Physician Assistants are not regulated

PAs are unregulated health professionals who work in a delegatory relationship with an MD.[4,6] Their roles and scope will ultimately be based on mutually agreed upon guidelines and directives between the MD and the PA. This does little to address the Pan-Canadian Planning Committee on Unregulated Health Care Workers recommendation to standardize job descriptions and titles of unregulated health care workers.[9] Further, though an unregulated health professional, PAs will be able, under delegation, to perform acts that are beyond the regulatory scope of other regulated professionals, including RNs and RN(EC)s.

Does the Ontario public not have the right to a regulated health professional? Does the Ontario public understand that PAs are not regulated and the implications of this? Throughout the literature in support of PAs, PAs are widely touted as 'highly skilled' care providers. *NURSES* **are** *highly skilled care providers*! And there is a body responsible for regulating our use and misuse of knowledge, skill, judgment and power to protect the public. There is no such body for PAs, other than the trust relationship built between the MD and the PA in the shadow of the inherent power and influence of the physician in the relationship.

Recruitment of PAs to primary care risks the underuse of nurses and nursing approaches to care in interdisciplinary teams.

CAOPA suggest that the essence of the MD-PA trust relationship is founded on their training in the medical model, which facilitates a common philosophical approach to physicians toward patient care.[3] CAOPA contrasts this with RN(EC)s (with no mention of RNs) being trained in the nursing model; yet provide no explanation or rationale as to why the skilled use of the nursing model is perceived as inferior in comparison to the 'interdisciplinary' use of the medical model as is implied.[6]

If CAOPA will appeal to US literature, so will we. A 2001 US study comparing the activities of RN(EC)s, PAs and MDs demonstrated that there was no statistically significant difference in the majority of aspects of the care provided between any of the professionals.[10] What the study did demonstrate was that patients who saw an RN(EC) received more counseling and education.[10] Nursing literature is replete with evidence on positive patient outcomes when education and counseling is achieved and personalized. In addition to supporting RN(EC)s working from a nursing model, this represents a strong case for RNs over PAs in primary care, where these and other functions are well within the scope of practice and can be provided at a more economically sustainable cost than PAs. The interdisciplinary inclusion of the nursing model should be viewed as an enhancement

ISSUES IN INTERDISCIPLINARY TEAMS

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of interdisciplinary care; while a PA represents a medical model-based professional that does little to articulate how it provides the holistic care which patients so appreciate from nurses.

Trust has already arisen as an issue limiting nursing practice in MD-RN relationships in primary care in Canada.[11] It is difficult to perceive that this is simply because nurses work from a nursing model, and that a new *unregulated* role will not face the same challenges that role definition ensues, in addition to creating new ones. Introducing this medical model-based worker risks exacerbating the difficulty of registered nurses in articulating and advocating for the relevance and importance of their roles in primary care teams; potentially hindering nursing's position to increase access to primary care. Introducing this role to primary care also risks task-shifting, potentially resulting in nurses working below their scope, with the potential effect of reducing the perceived value of nurses in primary care. From the perspectives of both nurses and health care teams, this could translate into decreased future recruitment and retention of RNs and RN(EC)s in primary care teams. The MOHLTC could be doing more to actively foster more effective collaborative MD-RN/MD-RN(EC) relationships and role developments as part of its primary care strategy rather than suggesting introducing a new health care role in primary care.

PAs are physician extenders and are not autonomous independent providers. There is a gap in evidence that suggests they present what CAOPA deems "the optimal choice for quality care"[6], particularly for primary care; especially if full scope of practice and medical directives for nurses were being more appropriately used. Now is the time for registered nurses in Ontario, and Canada, to advocate for its valid and effective role in primary care! OFPN wants your voices to be heard. We need to assure that RNAO recognizes that this impacts primary care RNs and RPNs, not only RN(EC)s, in order to best advocate for nursing in primary care in Ontario. We need the public and the government to support nursing over new unregulated roles. Please watch for an OFPN call to action with regard to the PA-issue in Ontario; or send us your suggestions or concerns regarding a call to action on this issue.

References:

[1]Registered Nurses' Association of Ontario. (2010). Position Statement: Physician Assistants. Retrieved from: http://www.rnao.org

[2]MOHLTC. (2009). Ontario's physician assistant initiative: An overview. Health Force Ontario. Retrieved from: http://www.healthforceontario.ca

[3]MOHLTC. The PA Project Team. (2010). PA project update. Health Force Ontario. Retrieved from: http://www.healthforceontario.ca/upload/en/work/paprojectupdatesummer2010.pdf

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[5]MOHLTC. (2009). Grants to support employment of graduate physician's assistants. Application information Package. Retrieved from: http://www.oha.com/Services/HealthProfessions/OtherHealthcareProviders/Documents/MOHLTC%20%20Information%20Package%20final%20(b).pdf

[6] Canadian Medical Association. (2010). Physician's Assistant toolkit: A resource for Canadian physicians. Retrieved from: http://www.healthforceontario.ca/upload/en/work/pa-toolkit_en.pdf

[7]Ministry of Health and Long Term Care (2010). Guide to interdisciplinary compensation. Retrieved from: http://www.health.gov.on.ca/transformation/fht/guides/fht_inter_provider.pdf

[8]Ontario Medical Association. (2009). OMA statement on physicians working with physician's assistants. Retrieved from: https://www.oma.org/Resources/Documents/2009PAOMAStatement.pdf

[9] Pan-Canadian Planning Committee on Unregulated Health Care Workers. (2009). Maximizing health human Resources. Retrieved from: http://www.cnanurses.ca/cna/documents/pdf/publications/UHW_Final_Report_e.pdf

[10]Hooker, R.S., & McCaig, L.F. (2001). Use of physician assistants and nurse practitioners in primary care, 1995-1999. *Health Affairs, 20*(4), 231-238.

[11]Akeryod, J., Oandasan, I., Alsaffar, A., Whitehead, C, & Lingard, L. (2009). Perception of the role of the registered nurse in an urban interprofessional academic family practice setting. *Nursing Leadership, 22*(2), 73-85.

FOCUS ON PEDIATRIC CARE

Active involvement in well child visits is certainly a valuable role for family practice nurses. The use of The Rourke Baby Record[1] is being more widely used by nurses as they collaborate within their interdisciplinary teams. As a set of guidelines, 'The Rourke' encourages primary care screening of visual acuity, per the *Canadian Pediatric Society's* recommendations[2], particularly in preschool aged children when there is the possibility of correcting some causes of diminished visual acuity. The most likely assessment by primary care nurses will be in the use an age appropriate Snellen chart, and our most likely nursing intervention is education.

The story below highlights one family's experience; it reveals the possibility of suboptimal screening, and the potential consequences. As we read this we should ask ourselves, what are we doing to prevent situations such as these?

Children in Junior Kindergarten in the Hamilton-Wentworth, Halton, Windsor-Essex and Dufferin-Peel Regions of Ontario are currently being recruited into the *Eye See Eye Learn Program*[3]. Families are sent letters from their children's junior kindergarten teachers. These letters are non-transferrable to other children. As mentioned in the story below, children in need of corrective lenses will get them for free! We should advocate for this program to become province wide! Please access the Eye See Eye Learn Website to learn more.

All primary care nurses in Ontario should be familiar with the program. Further we should be educating families about the need for eye exams that are more comprehensive, especially prior to schooling. Eye exams are covered by OHIP until age 19[3].

REFERNECES:
[1]The Rourke Baby Record: http://www.rourkebabyrecord.ca/
[2]The Canadian Pediatric Society, Statement on Vision Screening: http://www.cps.ca/english/statements/cp/cp09-02.html
[3]Eye See Eye Learn, Ontario Association of Optometrists: http://www.eyeseeeyelearn.ca

Kelly Pensom, RN, BScN
OFPN Communications Officer

MY PIRATE PRINCESS

My daughter turned 6 years old on July 8th, and on July 9th, an ophthalmologist informed us that she is legally blind in one eye, and likely has been since birth. She can see light and motion, but little else. Parental shock would be an understatement. I am sharing our story so that others don't fall through the cracks like we did.

With a background in healthcare, I made two assumptions, in error, along the way:

- Surely I would be savvy enough to recognize signs of vision impairment in my daughter; and
- The sight screening performed at our GP's office would act as an early warning system for any problems with her eyesight.

I was wrong on both counts. My daughter passed her annual GP visual screening, with flying colours no less, because she was asked to cover her own eye, and obviously cheated by peeking through her fingers. Sneaky little so-and-so!

Annual formal eye exams for children are covered by OHIP. The Ontario Association of Optometrists is rolling out the **Eye See…Eye Learn** program. This program was developed to raise awareness among parents of the importance of having their children's eyes examined by an eye professional **before** starting school. The program will provide free glasses to participating children, if they are required.

My daughter wears a patch over her 'strong' eye for 3 hours a day in order to force her brain to establish connections with her 'weak' eye. We try to empower her by let-

(Continued on page 8)

PROFESSIONAL ISSUES

CNO PROFESSIONAL LIABILITY RECOMMENDATIONS

You may be hearing about a new law requiring ALL professionals to carry personal professional liability protection. DON'T PANIC. This law has not yet been proclaimed. The College of Nurses is proposing to change its rules about this. PLEASE read the proposed amendment to the Registration Regulation which was enclosed with the Fall 2010 issue of *The Standard.*

A few things to think about:

1. This will not take effect until 2012; you actually have time to get yourself organized on this
2. RNAO membership offers Liability Insurance as a benefit of membership
3. Other groups are jumping on this bandwagon. I have received information from the Ontario Occupational Health Nurses Association advertising their Liability Insurance which is apparently available to all nurses in Ontario. I'm sure there will be others.
4. If you are an ONA member, ONA is in discussions with both the government and the College to make sure that their Liability Insurance will meet all requirements by the time it is necessary. ONA is concerned that the government seems to have created a situation where they are expecting nurses to accept wage freezes while at the same time making them pay out $200 a year for liability insurance. Also, for nurses employed in hospitals, public health, CCACs, and clinics, the requirement for all professionals to have individual insurance takes the onus off employers to carry vicarious liability insurance for their employees, which they do not feel is correct.

You will probably see lots of information on this in the next little while, much of it with a sense of urgency. Remember, the law is not yet proclaimed, and the College has not completed its consultation process which must precede any changes to its regulations. We have lots of time to figure this out.

On the other hand, you may want to start thinking about joining RNAO if you are not already a member, because, in the absence of any other insurance, that is a simple way to take care of the matter.

Judie Surridge, RN
OFPN President

Some insurance providers also offer professional liability coverage. Speak to your broker to learn more.

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My Pirate Princess

ting her choose which pattern to wear; today she chose the patch with the lipsticks and high-heeled shoes on it. That's my girl. Some days she jokes that she looks like a pirate princess. We are hopeful that we will see some improvement over the coming months, although we recognize that an earlier intervention may have been beneficial for her prognosis.

One in 6 children has some form of vision problem. My daughter excels at school, particularly with reading and penmanship, and there was *absolutely no indication* of impaired vision prior to her diagnosis. She didn't squint, she never complained of headaches, she embraced school and readily focused on tasks. We truly believed that the annual sight screenings would be a failsafe tool in our healthcare 'arsenal'. Parents need to understand that the sight screenings at the GP's office, while valuable, are not a substitute for a comprehensive eye examination by an eyesight professional.

Jennifer Hartman

EDUCATION PAGE

Family Practice Nursing
Ontario Graduate Certificate Program

Program Overview

The Registered Nurse - Family Practice Nursing certificate program prepares the Registered Nurse to provide comprehensive care to individuals and families across the lifespan within family health team/primary care contexts and settings. Current research and relevant theoretical perspectives provide the foundation of study for interprofessional family-centred care..

Unique Delivery

- Online Delivery Format - interactive learning, online discussions
- 2-3 terms
- 6 Courses:
  Evolution & Impact: Family Practice Nursing & Canada's Health Care System (42 hours)
  Leadership and Advocacy (42 hours)
  Using research to enhance Family Practice (42 hours)
  Quality, Risk and Workflow Management (28 hours)
  Assessment and Management (Term 1: 56 hours) (Term 2: 56 hours)
  Family Practice Nursing Clinical Practicum (16 hours/week X 12 weeks + 192 hours) - Preceptored Clinical Placement
- Underpinnings & Themes of Program: Primary Health Care Principles, Social Determinants of Health, RN Role in Health Promotion, Primary Prevention & Chronic Disease Prevention & Management, Intercollaborative Practice, and Health Technology.

Dianne Diniz, BScN, MEd
Chair, Collaborative Nursing Degree and Post Graduate Nursing programs
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416 415 5000, 3094

THIS PROGRAM IS PLANNED TO BEGIN FOR THE SEPTEMBER 2011 TERM

ARTICLES OF INTEREST

PERCEPTION OF THE ROLE OF THE REGISTERED NURSE IN AN URBAN INTERPROFESSIONAL ACADEMIC FAMILY PRACTICE SETTING

Akeryod, J., Oandasan, I., Alsaffar, A., Whitehead, C, & Lingard, L. (2009). *Nursing Leadership, 22*(2), 73-85. Can be retrieved from: http://www.fpnans.ca/webmedia/articles/nlvol22no2.pdf

FAMILY PRACTICE NURSES: THE TIME HAS COME

Oandasan, I., Hammond, M, Gotlib Conn, L., Callahan, S., Gallinaro, A., & Moaveni, A. (2010). *Canadian Family Physician, 56*(10), 375-382. Can be retrieved from: http://www.cfp.ca

INTERPROFESSIONAL COLLABORATION IN FAMILY HEALTH TEAMS

Goldman, J., Meuser, J., Rogers, J., Lawrie, L., Reeves, S. (2010). *Canadian Family Physician, 56*(10), 368-374. Can be retrieved from: http://www.cfp.ca

ONTARIO FAMILY PRACTICE NURSES

OFPN Membership Registration 2011

Please complete and return this form even if you have joined through RNAO*

Name: _____ RN: _____ RPN: _____

Mailing Address: _____---__

City: _____ Province: _____ Postal Code: _____

Telephone: Home: _____ Work: _____ ext: _____

E-mail: We will be sending the newsletter by email so please PRINT CLEARLY
_____

Employer: _____

Did you pay through RNAO? Yes___ No___ RNAO Membership #: _____

Please indicate the one chapter from where you would like to receive information (e.g. meetings, seminars, newsletter (if available) etc):

Chatham/Kent _____ Kingston _____
London and Area _____ Mississauga/Oakville _____ Ottawa _____
Toronto _____

Membership Fee: $60.00 per year (includes membership in the Canadian Family Practice Nurses Association)

Make cheque Payable to: "Ontario Family Practice Nurses"
Payable: (a) through RNAO or (b) directly to your Local Chapter or (c) to the address below.

☐ ***Check here if you do NOT wish to receive email information about professional and educational opportunities.***

PLEASE send this completed form to:

Barbara Thompson, RN, BScN
Membership Chair, OFPN
RR # 4
Meaford, ON, N4L 1W7

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Fax: 519-599-7127