The Guiding Light

CANADIAN SOCIETY OF GASTROENTEROLOGY NURSES & ASSOCIATES

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Look How Far We've Come in Gastroenterology

SYNOPSIS FROM PRESENTATION AT NATIONAL CONFERENCE SEPTEMBER 2000

by Nancy Campbell, RN

With the dawning of a new millennium, it only seemed fitting to include a presentation of the evolution of Gastroenterology over the past century. Due to time constraints a few topics were chosen.

Early in the 20th century, Gastroenterology was an undefined activity, without clinical or scientific guidelines. Physicians during this time had simple tools at their disposal. One must remember that fiberoptic endoscopy, biopsies of the stomach, small intestine and colon, needle biopsy of the liver, tests for hepatic and pancreatic function, breath tests, quality x-rays, ultrasonography, computerized abdominal tomography, assessments of GI motility and GI vascular status were not yet discovered. Such therapeutic resources as blood transfusions, sulfanomides, antibiotics, adrenal cortical steroids, immune modifiers, proton pump inhibitors, anti-inflammatories, nutritional supports, vaccines, cancer chemotherapy and organ transplants did not exist.

Gastrointestinal endoscopy has passed through 3 principle phases of technical development each identified by the predominant form of instrument then in use. They are the rigid scope era, the semiflexible scope era and the fiberoptic era. The rigid scope era was pioneered by Adolf Kussmaul in 1868. He developed the first gastroscope. Expanding on this design was Mikulicz who brought together the three elements of electric lightsource, optical system and tubular body.

In 1920, a Jewish physician by the name of Schindler created a semiflexible endoscope. He worked diligently to make gastroscopy a safer procedure and he also compiled and taught his findings. In 1940, Gastroenterology was declared a specialty. It was around this time that gastric biopsies were begun. Also, gastro photography using cameras inserted into the scopes was being done. However, due to the long exposure time required the pictures often were of poor quality.

The fiberoptic era began in 1957, when Dr. Basil Hirschowitz invented a prototype fiberscope. However, this scope was too flexible, resulting in frequent impaction. In 1964, air, water and suction channels were added to scopes. By 1971, instruments had been lengthened to 105 centimetres, and a 4 way control tip had been developed along with tip deflection improved to 180 and the masterscope through which smaller fiberscopes could be passed for diagnostic or surgical procedures were developed. Look how far we've come in Gastroenterology.

Let us trace the evolution of the treatment of ulcers. Prior to 1910, ulcers were more predominant in women than in men, prompting the emergence of the widely accepted theory that the wearing of tight corsets was responsible for ulcers. Resting the bowel or starvation, was the treatment of choice at this time. The Sippy Diet was based on the theory that the ulcer of the stomach or duodenum would

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heal as quickly as any other ulcer if it's granulating surfaces were not subject to digestive juices. The patient was kept on bedrest 2-3 weeks and fed a mixture of equal parts cream and milk every hour from 7 am to 7 pm. After 2-3 days, soft eggs and well cooked cereals were added. Cream soups, vegetable purees, custards, jellies, and junkets were also permitted. Alkaline powders were given with milk and cream midway between hourly feeds. They were continued every half hour from 7 pm to 10 pm. Often, stomach contents were aspirated at this time to remove all remaining food and secretions. The alkaline powders contained a mixture of heavy magnesium oxide plus sodium bicarbonate that were taken on the hour with milk and cream with a mixture of bismuth subcarbonate and sodium bicarbonate midway between feeds. This was followed for 12-18 months.

With the discovery of anaesthesia circa 1846 and antisepsis circa 1870, surgical approaches began to emerge. In 1881, Dr. Theodore Billroth performed a gastroduodenostomy, a procedure called a Billroth 1, later followed by a procedure call a Billroth 2, whereby, a partial gastrectomy with a gastrojejunostomy was performed. These basic procedures with numerous modifications remained the dominant treatment for peptic ulcers for the next 90 years.

In the 1920's in addition to keeping the patient npo for 3-7 days and on bedrest for 1-3 weeks, moist compresses were applied to the epigastrum and alcohol and saline were administered rectally QID. Opium and Belladonna were administered as analgesia. Oral feeding recommenced on day 3-7 and consisted of thin gruel and magnesium oxide. This starving regimen resulted in the deaths of many peptic ulcer patients.

A psychosomatic etiology emerged in 1930's as a cause of peptic ulcers. Ulcer patients were found to exhibit feelings of intense anxiety, insecurity, resentment, guilt, and frustration. Psychotherapy became a popular treatment with phenobarbital and cannabis often given in combination with anti-cholinergic drugs.

In 1943, performing vagotomy for treatment of duodenal ulcers began. Subsequently, a partial vagotomy coupled with a partial gastrectomy became the almost perfect ulcer operation.

On the pharmaceutical front the search for a gastric anti-secretory drug or H2 receptor antagonist produced it's first drug called Cimetidine in 1976, followed by Zantac. However, in spite of these drugs some patients remained symptomatic and unhealed and some developed tolerances. Later, with the discovery of the mechanism of the acid pump the drug Omeprazole was formulated. This drug could directly control acid secretion at it's source.

In the 1980's a spiral, flagellated bacterium called Helicobacter Pylori was identified as being present in peptic ulcer disease and gastric cancer. An antibiotic regimen pairing Amoxicillin and Clairithromycin along with Omeprazole has been shown to be an effective treatment to combat H Pylori. In September 1994 a link between gastric cancer and chronic active gastritis was confirmed.

With improved documentation came better diagnosis and treatment. The first documented case of Reflux Esophagitis was in 1933. By 1950, it was recognized that reflux could cause strictures and esophageal ulcers. At that time hiatus hernia was thought to be the prime cause of reflux. A surgical procedure called fundoplication was developed to fix this hernia and in some cases this procedure is still done today. However, with the discovery of pH measurement and further esophageal studies it was found that in many cases reflux is caused by the relaxation of the lower esophageal sphincter. With the view of the duodenum facilitated, it became easier to see the Ampulla of Vater. Endoscopic Retrograde Cholangiopancreatography or ERCP came into being. This procedure was first used as a diagnostic tool for biliary tract obstruction, jaundice problems secondary to biliary surgery, recurrent pancreatitis and obscure epigastric pain. In the mid 1970's therapeutic uses for ERCP emerged. Sphincterotomy, or the wire-cutting of the Papilla of Vater using electrocoagulation and the non-surgical removal of biliary calculi being the most common procedure done.

Percutaneous Endoscopic Gastrostomy or PEG was developed by two physicians as a means to longterm feed their pediatric patients in 1977. By 1981 PEG's were being used for adult feeding and today PEG insertion is a common procedure. Look how far we've come in Gastroenterology.

Simple anal speculi were found in the ruins of Pompeii. In 1894, the long rigid sigmoidoscope was introduced at John Hopkins University.

In 1965 in Sardinia, Italy the first total colonoscopy was performed. In 1971 the single lever polydirectional colonoscope was introduced. It was at this time that colonic polypectomy with a wire look snare and electrocoagulation was begun.

Video endoscopy emerged in the 1960's as a by-product of technical advances in microelectronics. The video endoscope dispensed with the lenses and fiberoptic bundles in favour of an electronic bundle at the tip of the instrument. This sensor transmitted the image electronically to a video processor. The image was then projected onto a TV screen. The first video was in 1983.

How far we have come in Gastroenterology in the past 100 years. Advances in ultrasound and computers have allowed the likes of virtual colonscopy to unfold like a Jacques Cousteau adventure. With the use of lasers and infrared beams smaller changes can now be identified. Perhaps in the near future it will be possible to establish the optical properties of tissues and to read structural changes of the surface of the mucous membranes using computers.

Look how far we've come in Gastroenterology!

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CANADIAN GUIDELINES FOR ENDOSCOPE REPROCESSING

Flexible endoscopy is becoming a very important tool in the diagnosis and treatment of gastrointestinal diseases. Its acceptance at large can be jeopardized when a patient questions the necessity of the procedure versus the risks associated with cross-contamination during the procedure.

To avoid uncertainty in the public's mind as to how endoscopes are reprocessed we should adhere to well-known CSGNA or the APIC guidelines. One less known, but as important tool in this quest, is the Canadian Standard Association (CSA Z314.8-00) which describes in all aspect the steps to follow to insure proper care of instruments and of anyone in contact with those instruments.

This well written standard *Decontamination of Reusable Medical Devices* not only gives detailed steps to follow, but also defines the language being used by indicating which action shall, should or may be carried out.

The word **shall** means **mandatory** requirement.

The word **should** means a **recommendation** or action should be followed.

The word **may** is used for an **optional** statement.

Section 14, describes the endoscope reprocessing steps.

1. "*Cleaning* **shall** commence immediately following completion of the clinical *procedure*". This is to prevent soil residue to dry in the channels.
2. A leak test **should** be performed after each use.
3. A damaged endoscope **shall** be removed from service.
4. We **shall** follow manufacturer's recommendations in preparing the endoscope to be shipped for repairs.
5. "Soaking and manual cleaning of all immersible endoscope components with water and a recommended cleaning *agent(s)* **shall** precede automated or further manual disinfection".
6. "All channels and lumens of the endoscope **shall** be flushed and brushed while submerged to remove debris while *minimizing aerosols*". Duodenoscope elevator channels **should** be cleaned and flushed manually to insure proper flow of detergent in these difficult-to-clean channels. In most cases the irrigation adapters for automated endoscope disinfectors do not flush liquid through the elevator channel.
7. "Irrigation adaptors or manifolds **shall** be utilized to facilitate cleaning. The adapter or manifold **shall** be compatible *with the endoscope*". There is a danger of having an inadequately processed instrument if the wrong adaptor is used.
8. "Devices **shall** be rinsed and dried prior to disinfection or sterilization". This step will prevent dilution of the sterilant or inadequate sterilization if the device is wet.
9. "*Final drying of the endoscope* **shall** be facilitated by flushing all channels, including the insertion tube, with 70% *isopropyl alcohol, followed by forced air purging of all channels*".
10. "*Channel valves* **shall** be thoroughly dried and should remain out of the endoscopes at the time of storage."
11. "*Endocopes* **shall** be stored hanging vertically in well-ventilated areas in a manner that minimizes contamination or *damage*".
12. "*Endoscope storage cabinets* **should** be cleaned and disinfected at least weekly".

The last point on the list is Endoscope Reprocessing Records. The CSA indicates that a permanent record of the processing procedures **shall** be completed and retained according to the policy of the facility. "*This record* **shall** include but not be limited to the identification number and type of endoscope, date and time of the clinical *procedure, results of each individual inspection and leak test, and the name of the person reprocessing the endoscope*". If possible, the name or ID of the patient linked to the device **should** be recorded to help tracking or quality control in case of an outbreak.

In an ideal world, every Endoscopic unit would follow these guidelines. My experience so far has demonstrated many interpretations: some good and some atypical. Hoping that with more education on the subject, more communication between parallel units and better follow-up measures will bring all Canadian centers to the high level we expect them to achieve and maintain. Let's all make an effort to adhere to the guidelines available as they are intended to insure the safety of all involved.

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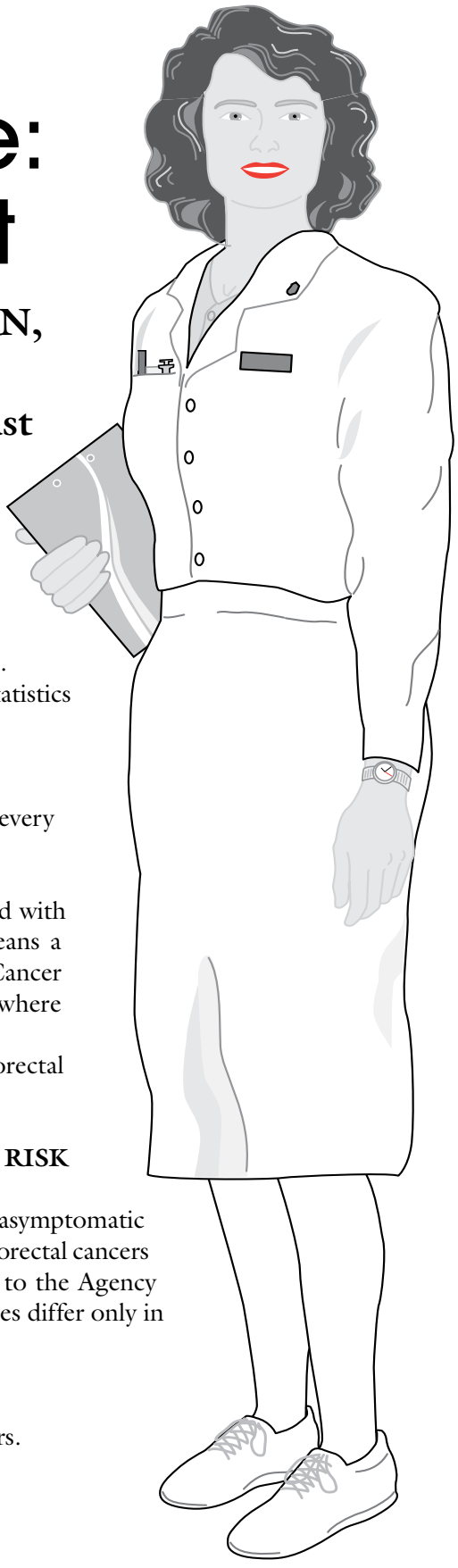
Advanced Gi Nursing Practice: Nurse Endoscopist

By Lorraine Miller Hamlyn, BN, RN, CGRN, President

& Linda Feltham, RN, Director Canada East

Canadian Society of Gastroenterology Nurses & Associates



1. BACKGROUND:

In Canada this year over 17,000 people will be diagnosed with colorectal cancer and more than 6000 Canadians will die from the disease. It is second only to Lung Cancer as a fatal cancer. (Canadian Cancer Statistics 2000).

A. COLORECTAL CANCER FACTS:

1. The risk of colorectal cancer rises sharply at age 50 years and doubles every decade thereafter.
2. Virtually all colorectal cancers arise from adenomateous polyps.
3. The identification and removal of adenomateous polyps is associated with a reduction in colorectal cancer incidence and mortality. This means a Colorectal Cancer Screening Program could prevent Colorectal Cancer unlike screening programs for Prostate Cancer and Breast Cancer where early detection of malignant lesions is the goal.
4. Flexible sigmoidoscopy is associated with a 45 - 80 reduction in colorectal cancer mortality.[14]

B. SCREENING RECOMMENDATIONS FOR THE AVERAGE RISK INDIVIDUAL:

Average Risk for colorectal cancer includes persons age 50 or older asymptomatic and with no other family or personal history of adenomateous polyps, colorectal cancers or other secreting organ cancers. The following are options according to the Agency for Health Care Policy and Research (American Cancer Society guidelines differ only in that fecal occult blood testing is not considered an adequate test).

1. Annual fecal occult blood (FOB).
2. Flexible sigmoidoscopy every five years.
3. Annual fecal occult blood and flexible sigmoidoscopy every five years.
4. Double contrast barium enema every 5 - 10 years.
5. Colonoscopy every 10 years.

FOB testing alone reduces the risk of death from colorectal cancer by only 15 - 33%. FOB combined with a flexible sigmoidoscopy is about 45 - 80% effective in reducing deaths from the disease. Patient education both in the need for screening and the need to return promptly if they develop new colorectal symptoms is vital to the success of the program in the prevention and early detection of colorectal cancer.

Nurses have performed flexible sigmoidoscopy since the 1970's both safely and effectively. The United States has nurses providing colorectal cancer screening programs, the United Kingdom and Australia are also involved in pilot studies.

Screening tests for colorectal cancer may change as new Non-invasive tests such as Virtual Colonoscopy and DNA testing of stool samples are developed and made available to the public. Recently the release of research results from a Stool Sample DNA Study at the Mayo Clinic, Rochester, Minn., suggests it is possible to identify abnormal cells in stool samples. Further testing will be needed to confirm the effectiveness of the procedure.

2. *INTRODUCTION:*

Canada's Healthcare System , including the Canadian Cancer Society, Health Canada and the Canadian Association of Gastroenterologists, has not made a formal recommendation on Colorectal Cancer Screening for the average risk person. The province of Ontario is offering one screening program with nurses performing screening flexible sigmoidoscopy. In the September issue of the "Canadian Medical Association Journal" there was a debate on the benefits/risks of offering a Colorectal Cancer Screening Program to all individuals age 50 and over. An Ontario lawyer who developed colon cancer at the age of 54 has started an organization called "Colorectal Cancer Screening Initiative Foundation" to increase the publics awareness of the disease and the need for a screening program in Canada.

A National Committee on Colorectal Cancer Screening was established in 1998 by the Health Protection Branch and the Health Programs and Promotion Branch of Health Canada. The role of the committee included the development of Colorectal Cancer Screening recommendations for Canada. The timeline for development of these guidelines is uncertain.(13)

In 1998 the CSGNA began research on Advanced GI Nursing Practice: "The Role of the Registered Nurse in the Performance of Flexible Sigmoidoscopy for the purpose of Colorectal Cancer Screening" in anticipation of the release of screening guidelines from Health Canada.

3. *CSGNA RESEARCH:*

A survey of ten Provincial Nursing Regulatory Associations showed there was no standard definition of Advanced Nursing Practice and the performance of Endoscopy Procedures by Registered Nurses had not been addressed. The Canadian Nurse Association was addressing the issue of Advanced Practice and has since developed "A Framework for Advanced Practice in Canada" to be used by member Provincial Regulatory Bodies in an attempt to standardize Canadian Practice.

The literature review did not produce any clear definition of Advanced Practice. Advanced Nursing Practice is used as an umbrella term to describe many areas of expanded nursing practice such as Clinical Nurse Specialist, Anaesthetic Nurse, Nurse Endoscopist and Nurse Practitioner. The preparation requirements vary from an experienced registered nurse to formal education at the graduate level.

A. MEMBER SURVEY:

CSGNA MEMBERS were surveyed to determine their interest in performing flexible sigmoidoscopy and the availability of colorectal cancer screening in Canada. 535 Surveys were mailed to CSGNA members. 91 replies (17%) were returned.

Results:

1. no nurses performing flexible sigmoidoscopies.
2. 16% interested in performing, 35% undecided.
3. 27% would consider advancing to the level of Nurse Practitioner if required to perform f/s.
4. 54% wanted monetary reimbursement for procedure.
5. 92% had trained Physicians able to provide training.
6. 30% had Physicians providing some colorectal cancer screening clinics.
7. 53% did not have the staff or facilities available to offer this service.
8. Two out of ten Provinces said there current scope of practice would allow for nurses to perform the procedure.

9. 98% felt their employers, would not support the practice.
10. 59% were advancing scopes under the physicians direction.
11. 10% prepared at Degree Level.
12. 58% had > 6 years Endoscopy experience and 36% > 11 years.

B. CONCERNS:

There were many concerns expressed re the nurse performing Flexible Sigmoidoscopies.

1. Physician support and training.
2. Requirements per year to remain proficient.
3. Increase in malpractice fees.
4. Support of employer and regulatory bodies.
5. Staffing.
6. Consents.
7. No video equipment.
8. Sedation.
9. Emergency coverage, Physician backup.
10. Workload.
11. Remuneration.
12. RN to assist with procedure.
13. Need for five years experience in Endoscopy to take on this role.
14. Therapeutic procedures to be repeated by Physicians.
15. Is there a need in Canada.

4. PRESENTATION TO MEMBERS:

At Gastro '99 in Vancouver, Canada, this information was presented to CSGNA members. During the discussion period following the presentation we heard from nurses representing the United States, Australia and England who were either in the process of setting up training programs for nurse performed endoscopies or were already performing procedures, both nurse performed Flexible Sigmoidoscopy and Gastroscopy.

The issue of whether the "Nurse Endoscopist" should be an independent practitioner or an Endoscopy Nurse trained to perform the procedure as part of her regular practice was discussed. There were concerns expressed regarding both practices.

The Endoscopy Nurse would be expected to perform regular duties when not performing procedures, conflict with other nurses in the unit, remuneration, procedure complication, physician support and legalities.

The CSGNA members present did express support for the CSGNA continuing with the development of a position statement and guidelines for Advanced Practice and Nurse Performed Flexible Sigmoidoscopy.

5. FOLLOW-UP:

During the next year we continued with our literature search and reviewed numerous articles on both advanced practice and nurse performed flexible sigmoidoscopy for the purpose of colorectal cancer screening. We adapted, with permission, the SGNA position statement "Role Delineation of the Advanced Practice Nurse in Gastroenterology/Hepatology and Endoscopy" and the "Guidelines for the Performance of Flexible Sigmoidoscopy by Registered Nurses for the Purpose of Colorectal Cancer Screening" to our Canadian practice. The first drafts of the position statement and guidelines were presented at the 2000 CSGNA Annual Conference in Ottawa, Canada.

A follow-up questionnaire was circulated to all attendees at the conference to measure any change in member interest. 104 replies returned.

A. RESULTS:

1. 59% interested in performing flexible sigmoidoscopy.
2. 34% nurse endoscopist should be nurse practitioner.
3. 68% nurse should have > 5 years experience.
4. 63% did not see a problem with the endoscopy nurse performing both the endoscopy nurse and endoscopist role.

B. CONCERNS:

Nurse Endoscopist must be assisted by another RN. Legalities, financial gains, physician availability, work relationships with physician and co-workers, skills assessment, ongoing evaluation, and is screening flexible sigmoidoscopy an adequate screening or should we be performing screening colonoscopy.

The worst bankrupt in the world is the person who has lost his enthusiasm.

6. *SUMMARY:*

The need for Colorectal Cancer Screening Programs for the average risk individual is clearly identified in the research that has been done on colorectal cancer. The issue of whether we should provide a flexible sigmoidoscopy or a colonoscopy has been raised. Other research shows there may not be a need for any invasive procedure in the future. Screening may be done through DNA testing or Virtual Colonoscopy. These test may be a long time coming as an accessible tool for colorectal screening. We must proceed with what we have available now and with the flexibility necessary to adapt to whatever screening tool becomes available in the future. One unnecessary death is one too many.

The success of Nurse provided programs is evident in the literature. The interest of our members in providing screening flexible sigmoidoscopies has increased as evidenced in our last survey. The concerns of our members have remained constant and must be addressed when introducing a training program for nurse performed procedures. Canadian Gastroenterology Nurses have a role to play in the provision of a Colorectal cancer screening program for Canadian citizens. We will continue to move forward with our preparation.

The position statement on "Advanced Practice", and the "Guidelines for Nurse Performed Flexible Sigmoidoscopy", will be published in "The Guiding Light", as soon as they are completed and passed by the CSGNA Board of Directors.

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CHANGE OF NAME ADDRESS/NAME

Name: _____

New Address: _____

City: _____ Province: _____

Postal Code: _____ Phone: _____

Fax: _____ E-Mail: _____

MOVING?
LET US KNOW!

Remember to send in your change of address!

PRESIDENT'S REPORT

Happy New Year! I trust you all had a wonderful holiday season. I hope your new year's resolutions involved a renewed commitment to the CSGNA. Your board of directors have been busy continuing to fulfill their commitments to the CSGNA and our members. The next scheduled Board meeting is March 16 to 18, 2001. If you have any issues or concerns that you want the Board to address, please send them to the Board of Directors attention via your Regional Representative or directly to me.

We need VOLUNTEERS!!! Nominations are still open for seven board positions:

Director for each region: Canada East, West and Center – two year term
Director Canada Center – one year term
Secretary – two year term
Treasurer/Membership Chair – two year term
Education Chair – two year term

If you love a challenge, are not afraid of hard work, are committed to the CSGNA and to the promotion of Gastroenterology Nursing and Excellence in Patient Care, like to meet new people and network with Gastroenterology Nurses from around the world, and you want a Leadership Role in the future of our Specialty, then you must run for a Board Position. We need you!!

As the quote says, "If not you, who. If not now, when." You have something unique only you can give. Get Involved! Volunteer Now! It is a very rewarding commitment both professionally and personally.

The duties and responsibilities of the board positions are listed in the CSGNA Bylaws, published in the November 2000 issue of "The Guiding Light". If you require any further information you can contact myself or any member of the National Board.

Please submit all nominations to Chair of Nominations Committee (President CSGNA), 180 Waterford Br. Rd., St. John's, NF, A1E 1E2 by April 30th, 2001.

The nomination forms are included in The Guiding Light and may be photocopied for submission. Please take this opportunity to volunteer for a position on the Board or encourage another member to run.

Submitted by
Lorraine Miller Hamilyn

PROUD TO BE A PROFESSIONAL!

After attending the Annual CSGNA Conference in Ottawa last September I have once again become renewed.

Listening to Nancy Campbells' excellent rendition of "Look How Far We Have Come In Gastroenterology" has rekindled the flame of energy in myself and hopefully many others who were in Ottawa. To be able to understand where we started and to see and experience where we are and where we are going is truly exciting. Expanding scopes of practice, and advancements in endoscopic modalities are only some of the topics. The discussions of some controversial topics such as nurses performing endoscopy and the reuse of single use devices is always stimulating when nurses from all across the Continent meet. Listening and discussing these and many other topics have improved the quality of GI nursing right around the globe.

Many of us had the pleasure of meeting Margaret Coffey, SGNA President-Elect from Savannah, Georgia. Although Margaret was not charmed by our weather she was certainly charmed by our Conference. The professionalism in which the Conference was handled and executed with is to be commended. We have truly put CSGNA on the map. We are becoming more recognizable and more credible as the years go by. This is being successfully accomplished by the members of the CSGNA which is YOU. As the year 2001 unfolds we find the CSGNA on the brink of attaining societal status and acquiring our own certification exam. These are items awarded to professional groups, and we are proud to be one of them.

Submitted by Lorie McGeough,
CSGNA President-Elect

MEMBERSHIP/TREASURER REPORT

The funds in our Operational account are from our membership dues, national conference registration, and exhibitor booths, plus support from our generous sponsors. The funds in our educational account are from the 25% profit each chapter submits post Educational Days, and Scholarships donated by our sponsors.

Any questions or concerns regarding ***YOUR*** money please contact me, or any member of the Executive.

It's time again to renew your annual membership for the 2001-2002 year. The fee is $40.00. Our renewal date will continue to be the month of June. Membership is down from last year, as we all are aware of the ever changing system in our health care today the benefits of being a member are: ongoing networking with colleagues from across the country, keeping abreast of current research and technology, position statements

You will become as small as your controlling desire;
as great as your dominant aspiration.

and guidelines, scholarships, CSGNA website and our goal of certification. Please encourage your friends and colleagues to become members. Please fill out membership application forms when you renew and send any changes of name or address & e-mail address to the address bellow.

Please direct your membership application to:
Edna Lang
CSGNA Treasurer/Membership Chair
27 Nicholson Dr.,
Lakeside NS B3T 1B3

I would like to welcome the following new members:

Anne Batey	Victoria, BC
Maria Fleming	Victoria, BC
Danielle Joslin	Victoria, BC
JoAnne Baldassi	Bench Trail, BC
Charlene McCabe	Victoria, BC
Sonja Shaw	Nelson, BC
Ju Ho Barbara Yu-Chee	Vancouver, BC
Alfreda Tang	Vancouver, BC
Nancy Pool	Nanaimo, BC
Barbara Waters	Edmonton, AB
Shirley Glasgow	Calgary, AB
Louise Nadeau	Wetaskiwin, AB
Mary Russell	Calgary, AB
Bourgieois-Burton	Calgary, AB
Cheryl Clarke	Calgary, AB
Carol Berry	Edmonton, AB
Jacinta Cooke	Calgary, AB
Dayna Henkelman	Calgary, AB
Janina Kravec	Calgary, AB
Joan Templeman	Calgary, AB
Meredith Wild	Calgary, AB
Louise Wheatcroft	Edmonton, AB
Shelley Bible	Edmonton, AB
Pat Merriam	Nepeon, ON
Krista Murphy	Toronto, ON
Sharon McCarthy	Kingston, ON
Patricia Michelutti	Oakville, ON
Kimberley Morrissette	Chelmsford, ON
Barbara Nadolski	Ottawa, ON
Francine Nyentap	Russell, ON
John Owens	North Bay, ON
Rosemarie Paz	Mississauga, ON
Valerie Patsakos	Toronto, ON
Irene Pridham	North York, ON
Diane Querin	Kitchener, ON
Irene Richard	Pembroke, ON
Jean Richmond	Roblin, ON
Starr Rohal	Burlington, ON
Seta Prashad	Scarborough, ON
Jean Richmond	Roblin, ON
Nichole Riverst	Hearst, ON
Brenda Purcell	Stratford, ON
Eileen Rideout	Brampton, ON
Grace Ruhnke	Peterborough, ON
Shakir Saffee	Scarborough, ON
Daysi Sandino	Mississauga, ON
Carolyn Saint-Yves	Cumberland, ON
Joan Staddon	Lasalle, ON
Ken Takamaki	Brampton, ON
Addie Vidler	Newmarket, ON
Kathryn Wachmann	Norval, ON
Judith Witt	Pembroke, ON
Linda Wray	Seagrave, ON
Deborah Weddel	New Market, ON
Elaine Richmond	Montreal, Que
Helena Kalinowski	Brossard, Que
Sharon Miller	Chateauguay, Que
Branda Hebb	Riverview, NB
Mary Smearer	Bellrdune, NB
Karen Copp	Miramichi, NB
Eileen Curley	Charlottetown, PEI
Irene Cottreau	Yarmouth, NS
Shelley Slipp	Wolfville, NS
Judy Martin	Stellarton, NS
Dale Duerford	Yellowknife, NT
Melia Zipp	Saskatoon, SK
Linda Buchanan	Regina, SK
Jennifer Donison	Regina, SK
Cheryl Loucks	Regina, SK
Laurie Schmidt	Regina, SK
Marian Svenson	Regina, SK
Dianne Tycholaz	Saskatoon, SK
Colleen Gerow	Saskatoon, SK
Patricia Woychuk	Saskatoon, SK
Louise Werner	Dalmeny, SK
Mike Delorme	Winnipeg, MB
Sherri Allin	Ashton, ON
Leticia Apostol	Oshawa, ON
Janet Allen	Kingston, ON
Catherine Baxter	Orleans, ON
Janet Boudens	Killaloe, ON
Mary Budgell	Ottawa, ON
Maria Cirocco	North York, ON
Nicole Craige	Gloucester, ON
Letica Clarke	Toronto, ON
Patricia Cuddy	Sanford, ON
Joanne Dignem	Whitby, ON
Gisele Delaire	Sudbury, ON
Executive Leader OR/Pacu	Tillsonburg, ON
Holly Ballie	Hamilton, ON
Lynn Labbett	Boltom, ON
Cheryl Milani	Hamilton, ON
Mary Martin	Milton, ON
Theresa Smith	Millgrave, ON
Mary Lou Domingo	North York, ON
Colleen Doyon	Cornwall, ON
Beth Fachnie	Hamilton, ON
David Fraser	Bowmanville, ON
Shirley Foster	Port Perry, ON
Nancy Genge	Kingston, ON
Karen Germann	Whitby, ON
Margaret Hackert	Elmira, ON
Renee Henry	Thornhill, ON
Brenda Hillier	Dundas, ON
Laurie Hamilton	Lakefield, ON
Yvonne Hart	Dundas, ON
Deborah Holmes	London, ON
Jane Jandron	Toronto, ON
Lynn Kyte	North York, ON
Debbie Kidd	Peterborough, ON
Margaret Leduc	Toronto, ON
Wendy Lee-Foster	Port Perry, ON
Jeanette Lambert	Barrie, ON
Patti Leonard	Orillia, ON
Sylvie Lepine	Ottawa, ON
Patti Ley	Cobourg, ON
Markowski	Kingston, ON
Diana McQuaig	Peterborough, ON

Submitted by Edna Lang

CANADA EAST REPORT

In October the NB/PEI chapter held its annual Education Day at the Moncton Hospital. Nineteen nurses attended. The annual business meeting took place and election for the new executive were held. Fran Duguay assumed the role of president and Mary Eva Smearer assumes the joint role

of secretary/treasurer. Both of these nurses work in Bathurst, NB.

The Nova Scotia Chapter has been quiet for the past several months however, plans are underway for an education day to be held April 28/01. The day will focus on infection control and Carsen will be presenting a 1/2 day session on scope care and cleaning.

Submitted by Evelyn McMullen, Director Canada East

CANADA CENTRE OTTAWA CHAPTER

The Ottawa Chapter began planning for this year at it's Christmas Potluck Dinner. Suggestions are always welcome from the membership who were unable to attend our last meeting. I will be attending the National face to face in March and participated in a teleconference in January. GI nurses we are getting closer to the reality of certification! I encourage you to communicate your nursing concerns to me and to keep the lines of communication open and functioning.

Yours in CSGNA,
Nancy Campbell

CANADA EAST REPORT NEWFOUNDLAND AND LABRADOR CHAPTER

A chapter meeting was held at the St. Clare's site in October with a discussion on the 2000 national CSGNA conference presentations and feedback from other colleagues. We are still waiting for confirmation dates for the Atlantic meeting in June 2001. The national CSGNA will be September 20-22, 2002 in St. John's, NFLD. at the Delta Hotel. When more information becomes available it will be passed onto the members.

Due to terrible winter weather the chapter has been unable to meet but we are hoping for either early or mid March to meet again.

During the week of February 5 two representatives from Carsen visited the endo suites (St. Clares and HSC) to observe and review the cleaning and disinfecting of scopes and accessories with staff.

The next CSGNA board meeting will be the weekend of March 16. If you have any questions, concerns or suggestions I will be happy to present them at that time. This can be forwarded to me by mail, fax or call as listed on back of The Guiding Light.

Sincerely, Linda Feltham

CANADA CENTRE REPORT

Southwestern Ontario Chapter is planning an education session for the spring. Details will be posted on the web site as it becomes available.

London and Area Chapter is planning an education evening for the spring. Topic will possibly be on Endoscopic Ultrasound or Managing Upper GI Bleed.

The Golden Horseshoe Chapter is also planning an education evening for the spring. Details will be available on the web site when I have more information on it.

The Greater Toronto Chapter had an education evening in the fall on Scope Cleaning presented by Carsen. It was well attended and very informative. Our thanks to Carsen for sponsoring the evening. The Chapter elected a new President to replace Kay Rhodes, since she is now part of the National. Gail Stewart is now the President for the Toronto Chapter. The Secretary is Elaine Burgis and Treasurer is Brenda Latch. The Greater Toronto Chapter has been busy planning an education evening for Tuesday, February 20th on Endoscopic Reprocessing and sponsored by SciCan. I do hope to see many of you there.

Sincerely, Sandy Saioud

CANADA WEST REPORT

VANCOUVER ISLAND

Chapter president Irene Ohly reports that the chapter has welcomed 4 new members. ERCP accessories were reviewed at their last inservice which was presented by Nelda Turner. A chapter meeting was held on January 8, 2001. Topics for future education sessions and certification were discussed.

VANCOUVER REGIONAL

Chapter president Gail Whitley reports that their education workshop on November 18 was a great success. There were 40 attendees and 12 vendor tables. Lorie McGeough's presentation on "To Use and Use Again" generated a lively discussion. The chapter is hosting a dinner and baby shower for one of their vendors in February. A chapter meeting is scheduled for an evening in March.

OKANAGAN CHAPTER

Chapter president Linda Fransden and her husband have left for the winter to travel around South America. They left Kelowna in mid November and will return in April. Presently they are staying with a friend in Ecuador. In her absence, Chapter treasurer, Deb Levine, is assuming the role of president. She reports that Dr. Bill Novak gave a presentation on "Remicade" in mid November which was attended by all their members. Future education sessions will be planned on Linda's return.

SASKATCHEWAN CHAPTER

Chapter president Elaine Fehr reports that "Gastroenterology Days for Nurses" which was held on October 13 was a huge success. It was attended by 87 participants. The chapter is now busy making videos of various G.I. Endoscopic procedures to present at their 2001 education day.

Respectfully submitted by
Evelyn Hilderman,
Director, Canada West

WESTERN DIRECTOR REPORT

We are definitely enjoying a wonderful winter out west this year. I know the skiers aren't happy but I love it.

MANITOBA CHAPTER

Their November, 2000 meeting was sponsored by Marg Valcour of SCI CAN. She presented an educational session on Enzymatic Detergents/ High Level Disinfection Chemistries. Their February meeting will have an educational session on Manometry. They are also planning a one day conference for April 28, 2001. A big welcome to the new executive members.

CALGARY CHAPTER

The December, 2000 meeting was a business meeting that included an educational session on Endo Clips and Loops. It was sponsored and given by Carsen Group's, Bill Collins and Dan London. They planned their January, 2001 meeting to include an inservice on Colonic Stents.

EDMONTON CHAPTER

Leadership and Empowerment for Women by Liz Reid was a workshop held at the November, 2000 meeting. The chapter has been working hard on planning for the National Conference, September, 2001. The theme for the conference is *2001 – an Edmonton G.I. Odyssey – Challenges for the 21st Century.* It is planned for September 28, 29, 30, 2001 at the Fantasyland Hotel in Edmonton, Alberta. Some of the topics we have confirmed are:

Pain control in the G.I. patient
Exemplary Nursing
Home Nutrition Support Program
Ethical Issues in Tube Feeding
Alternative Medicine – Hope or Hype
Advanced Nursing Practise in Gastroenterology
Humour for Your Health

We are also looking forward to seeing many of our suppliers in the exhibitors hall. The sponsored entertainment in the evenings will be great as well – we're still working on that. Do make plans to join us in September, 2001.

Submitted by
Judy Langner, Western Director

EDUCATION COMMITTEE

Orientation manuals have been very successful. There is still time to apply for the CAG scholarship.

Submitted by Marlene Scrivens

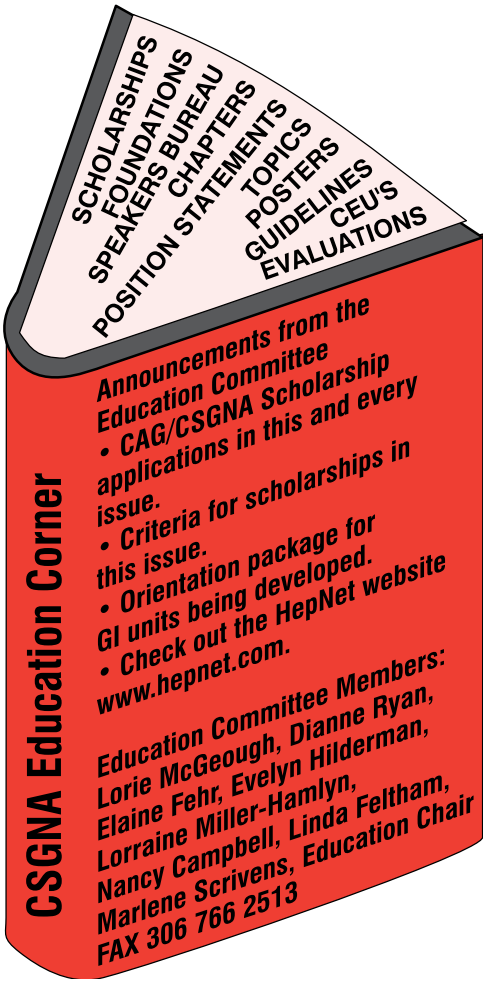
GUIDELINES FOR SUBMISSION to *"THE GUIDING LIGHT"*

- white paper with dimensions of 81/2 x 11 inches
- double space
- typewritten
- margin of 1 inch
- submission must be in the possession of the newsletter editor 6 weeks prior to the next issue
- keep a copy of submission for your record
- All submissions to the newsletter "The Guiding Light" will not be returned.

C.S.G.N.A. DISCLAIMER

The Canadian Society of Gastroenterology Nurses and Associates is proud to present The Guiding Light newsletter as an educational tool for use in developing/promoting your own policies and procedures and protocols.

The Canadian Society of Gastroenterology Nurses and Associates does not assume any responsibility for the practices or recommendations of any individual, or for the practices and policies of any Gastroenterology Unit or endoscopy unit.



WORD SEARCH

BY ELAINE FEHR

AMYLASE
ALPHA
AMINOTRANSFERASE
ACINAR
DATA
BILIRUBIN
BETA CELLS
CANCER
DUODENUM
DUCT
CHYME
ENZYMES
ENDOCRINE
ERCP
FEVER
GLUCOSE
GLUCAGEN
HYPERGLYCEMIA
HYPOXIA
HYPOTENSION
HYPOCALCEMIA
INSULIN
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LIPASE
LUMINA
LOBULES
PSEUDOCYSTS
PANCREATITIS
PANCREAS
PAIN
PARASYMPATHETIC

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T	C	U	D	C	U	P	A	N	C	R	E	A	T	I	T	I	S	X	N
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Richmond, BC V7E 6A3
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Treasurer: Nala Murray

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3320 Jackson Court
Kelowna, BC V1W 2T6
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Secretary: Arlene Schroeder
Treasurer: Debb Levine

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Calgary, AB T2T 1E1
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(403) 291-1599 (F)
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Treasurer: Doreen Reid

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Ancaster, ON L9G 1P1
(905) 648-8771 (H)
(905) 521-2100 Ext. 5350 (B)
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New Brunswick and PEI Chapter
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(506) 545-2408 (B)
Secretary/Treasurer Mary Eva Smearer

Nova Scotia Chapter
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Westphal, NS B2Z 1H2
(902) 473-6541
Secretary: Donna Cook
Treasurer: Theresa McKinon

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Canadian Society of Gastroenterology Nurses & Associates

2001:

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SEPTEMBER 26-30, 2001

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Canadian Society of Gastroenterology Nurses & Associates

C/O EDUCATION CHAIR: MARLENE SCRIVENS, 2107 BONNEAU PLACE, REGINA, SASK. S4V 0L4

APPLICATION FORM
FOR CSGNA REGIONAL SCHOLARSHIPS AWARD

The Regional Conference award of $400.00 is to be used for travel and accommodation to a Regional Conference in Canada. Six scholarships will be awarded yearly.

EXCEPTIONS:

1. Applicant cannot have received **THIS** award in the previous two years.
2. Current members of the Executive and Conference Planning Committee are not eligible for this award.
3. Scholarships are available only to active members.

PLEASE SUBMIT THE FOLLOWING WITH THIS APPLICATION:

1. A written summary of how this scholarship and attendance at the proposed meeting would benefit you in your work.
2. A current Curriculum Vitae.
3. Please specify your past involvement in the CSGNA: e.g., acted as speaker at a meeting, actively recruited new members for CSGNA, aided in the formation of a local Chapter, served on an Ad Hoc Committee, and any Newsletter articles submitted. Describe your current involvement with your Chapter: e.g., fundraising or planning Chapter conferences.
4. Outline projected financial needs to attend this meeting.
5. Geographical location and related travel expenses will be taken into consideration by the Education Committee when scoring applications.

APPLICATION FORM AND SUBMISSIONS MUST BE RECEIVED BY THE EDUCATION CHAIR AT THE ABOVE ADDRESS AT LEAST 8 WEEKS PRIOR TO THE EVENT.

NAME: _____

CIRCLE ALL THAT APPLY: RN BSN BAN MSN OTHER _____

HOME ADDRESS: _____

CITY: _____ PROV: _____

POSTAL CODE: _____ HOME TELEPHONE: ( ) _____

FAX: ( ) _____

NAME OF THE MEETING YOU WISH TO ATTEND: _____

DATE OF THE MEETING : _____

CITY WHERE PROPOSED MEETING WILL BE HELD: _____

JOINED THE CSGNA IN 19_____

SIGNATURE _____ DATE _____

Canadian Society of Gastroenterology Nurses & Associates
C/O EDUCATION CHAIR: MARLENE SCRIVENS, 2107 BONNEAU PLACE, REGINA, SASK. S4V 0L4

APPLICATION FORM FOR CSGNA ANNUAL SCHOLARSHIP AWARD

The Annual National Conference award of $700.00 is to be used for travel and accommodation to the Annual National Conference in Canada.

EXCEPTIONS:

1. Applicant cannot have received **THIS** award in the previous two years.
2. Current members of the Executive and Conference Planning Committee are not eligible for this award.
3. Scholarships are available only to active members.

PLEASE SUBMIT THE FOLLOWING WITH THIS APPLICATION:

1. A written summary of how this scholarship and attendance at the proposed meeting would benefit you in your work.
2. A current Curriculum vitae.
3. Please specify your past involvement in the CSGNA: e.g., acted as speaker at a meeting, actively recruited new members for CSGNA, aided in the formation of a local Chapter, served on an Ad Hoc Committee and any Newsletter articles submitted . Describe your current involvement with your Chapter: e.g., fundraising or planning Chapter conferences.
4. Outline projected financial needs to attend this meeting.
5. Geographical location and related travel expenses will be taken into consideration by the Education Committee when scoring applications.

APPLICATION FORM AND SUBMISSIONS MUST BE RECEIVED BY THE EDUCATION CHAIR AT THE ABOVE ADDRESS BY JUNE 1 OF THE CURRENT YEAR.

NAME: _____

CIRCLE ALL THAT APPLY: RN BSN BAN MSN OTHER _____

HOME ADDRESS: _____

CITY: _____ **PROV:** _____

POSTAL CODE: _____ **HOME TELEPHONE: ( )** _____

FAX: ( ) _____

HOSPITAL / EMPLOYER: _____

WORK ADDRESS: _____

CITY: _____ **PROV:** _____

POSTAL CODE: _____ **JOINED THE CSGNA IN 19___**

SIGNATURE: _____ **DATE:** _____

Canadian Society of Gastroenterology Nurses & Associates
C/O EDUCATION CHAIR: MARLENE SCRIVENS, 2107 BONNEAU PLACE, REGINA, SASK. S4V 0L4

APPLICATION FORM FOR CAG NURSE SCHOLARSHIP PRIZES

The Canadian Association of Gastroenterologists (CAG) scholarship prizes are available to one research nurse and one endoscopy nurse in the amount of $500.00 each, to be used for travel to an appropriate endoscopic gastroenterology or research meeting. The CAG nurse scholarship prize is sponsored by an Educational Grant from the Canadian Association of Gastroenterology.

ELIGIBILITY:

1. You are and have been for two years or more, an active member of the CSGNA.
2. You actively support CSGNA goals and objectives.

PRIZE APPLYING FOR: (please circle one) RESEARCH NURSE ENDOSCOPY NURSE

PLEASE SUBMIT THE FOLLOWING WITH THIS APPLICATION:

1. A two page summary of how this scholarship and attendance at the proposed meeting would benefit you in your research / endo - clinical role in gastroenterology, and what self initiated research projects you are involved in.
2. A current Curriculum Vitae.
3. A letter of reference from your Unit Director.
4. Two letters of reference from CAG members.

APPLICATION FORMS AND SUBMISSIONS MUST BE RECEIVED BY THE EDUCATION CHAIR AT THE ABOVE ADDRESS BY FEBRUARY 15 OF THE CURRENT YEAR. THEY WILL BE FORWARDED TO THE SECRETARY OF THE CAG FOR SELECTION.

NAME: _____

CIRCLE ALL THAT APPLY: RN BSN BAN MSN OTHER _____

HOME ADDRESS: _____

CITY: _____ **PROV:** _____ **POSTAL CODE:** _____

HOME TELEPHONE: ( ) _____ FAX: ( ) _____

HOSPITAL / EMPLOYER: _____

WORK ADDRESS: _____

CITY: _____ **PROV:** _____ **POSTAL CODE:** _____

NAME OF DIRECTOR OF UNIT: _____

NAME OF THE MEETING YOU WISH TO ATTEND: _____

DATE OF THE MEETING: _____ **CITY WHERE MEETING WILL BE HELD:** _____

JOINED THE CSGNA IN 19____

SIGNATURE: _____ **DATE:** _____

Canadian Society of Gastroenterology Nurses & Associates
180 Waterford Br. Rd., St. John's, Newfoundland A1E 1E2

NOMINATION FORM

Please complete this form and submit to the Chair of the Nominations Committee (currently the President of the CSGNA) 150 days before the Annual Meeting for national office. Ballots will be sent to the active members 120 days before the Annual meeting and must be returned within 90 days.

Candidates must be active CSGNA members in good standing.

Name of nominee: _____

Address: _____

_____ Postal Code _____

Phone (home) _____ (work) _____

Employer: _____

Title: _____

Education: _____

CSGNA member since: _____

Offices held: _____

Committees: _____

Other related activities: _____

_____

Explain what has led you to chose to run for national office? _____

_____

_____

I hereby accept this nomination for the position of _____

dated this _____ day of _____ 19_____. Signed _____

Nominated by _____ & _____

SIGNEA MEMBERSHIP
MEMBERSHIP APPLICATION

SOCIETY OF INTERNATIONAL GASTROENTEROLOGICAL NURSES AND ENDOSCOPY ASSOCIATES

Individual Membership

Individual Memberships for Gastroenterological Nurses and Endoscopy Associates are available for $10.00 annually ($US).

Affiliate Membership

Individuals interested in joining SIGNEA, such as physicians, other medical professionals, and non G.E. nurses, pay affiliate membership fees of $50 annually ($US).

National G.E. Nursing Organization Membership

Membership in SIGNEA is available to national nursing organizations. Membership inquiries may be sent to the SIGNEA Secretariat. National G.E. Nursing organization dues are dependent upon the number of national members in each organization. Membership applications should be accompanied by payment and the name of the organization's official contact person.

Corporate Membership

SIGNEA welcomes corporate memberships by companies which supply G.E. products, drugs, general medical equipment and any service that would be utilized by G.E. nurses. Detailed corporate membership information may be obtained from: Pat Pethigal, Chair, fax: 206.223.6379, phone: 206.223.6965 or the SIGNEA Secretariat.

Check Membership Level/Payment		1 year	2 year	3 year
Individual Membership		$10 ❑	$20 ❑	$30 ❑
Affiliate Membership		$50 ❑	$100 ❑	$150 ❑
National G.E. Nursing Membership	up to 100	$50 ❑	$100 ❑	$150 ❑
	101 - 400	$200 ❑	$400 ❑	$600 ❑
	401 - 1,000	$400 ❑	$800 ❑	$1,200 ❑
	Over 1,000	$750 ❑	$1,500 ❑	$2,250 ❑
Corporate Membership		$1,000 ❑	$2,000 ❑	$3,000 ❑

Please add an additional $15 for those checks that are drawn off Non-US banks. $ _____ Total Pymnt.

WORKPLACE
- ❑ Endoscopy Unit/Hospital
- ❑ Endoscopy Unit/Clinic
- ❑ Inpatient/Outpatient

POSITION
- ❑ Administrative/Director
- ❑ Consultant Nurse
- ❑ Head Nurse
- ❑ Staff Nurse
- ❑ Supervisor/Coordinator
- ❑ Technician (Patient Care)
- ❑ Clinical Specialist
- ❑ Educator
- ❑ Researcher
- ❑ Technician (machine)
- ❑ Nurse Practitioner
- ❑ Manufacturer Representative
- ❑ Corporate nurse Consultant
- ❑ Other_____

 # Years Education/Training
- _____ 1 Year
- _____ 2 Year
- _____ 3 Year
- _____ 4 Year
- _____ 5 Year

First Name (Given Name)

Last Name (Family Name)

Address for Mail **City**

State/Province **Country** **Postal Code**

Telephone **Fax** **Email address**

Employing Organization **Title**

Send completed form to:

Kimberly Svevo, SIGNEA
401 N. Michigan Ave., Suite 2200 Chicago, IL 60611 USA
Phone: 312.644.6610 Fax: 312.321.6869 E-mail: kimsvevo@sba.com

SGNA Membership Application

CONTACT INFORMATION (Please print or type.)

First MI Last

Nickname

Hospital/Office/Company Name

Social Security Number Date of Birth

Credentials

Nursing: ☐ RN ☐ LPN ☐ LVN

Education: ☐ PhD ☐ MSN ☐ MS ☐ BSN ☐ BS ☐ ADN ☐ DIPL

Certification: ☐ CGRN ☐ CGN ☐ CGA ☐ CGT ☐ CGC ☐ Other_____

Certification Date:_____

Other Training: ☐ Technician ☐ Nursing Assistant

Please provide both addresses and check your preferred mailing address:

☐ **Work**

Street Address_____

City_____

State/Province_____ Zip_____

Country_____

Phone_____

Fax_____

☐ **Home**

Street Address_____

City_____

State/Province_____ Zip_____

Country_____

Phone_____

Internet/E-Mail Address_____

REFERRED BY_____
(If applicable)

PROFESSIONAL PROFILE

1.) Professional Setting (Check one.)

☐ Free Standing/ Ambulatory ☐ Equipment Sales
☐ GI Clinic ☐ GI Nursing Floor
☐ Inpatient Only ☐ Outpatient Only
☐ Inpatient/Outpatient Combination ☐ Manufacturer
☐ Physicians Office
☐ Other_____

2.) Position (Check one.)

☐ Administrative/ Director ☐ Clinical Specialist
☐ Consultant ☐ Educator
☐ Head Nurse ☐ Researcher
☐ Staff Nurse ☐ Nurse Practitioner
☐ Supervisor/ Coordinator ☐ Sales
☐ Technician (patient care) ☐ Technician (machine)
☐ Other_____

3.) Memberships in Other Nursing Organizations (Check all that apply.)

☐ ANA/SNA ☐ AACN
☐ ENA ☐ ASPAN
☐ AORN ☐ Sigma Theta Tau
☐ Other_____

PAYMENT INFORMATION • *dues subject to change*

A. Membership (SGNA membership runs on a calendar year and is renewable by January 1 of the following year.)
Check the category of membership for which you are applying:

Voting Status	Type	Definition	Annual Dues	Prorated Dues (If joining after July 1)
☐ Voting	Licensed Nurse	Limited to Registered Nurses and Licensed Vocational/ Practical Nurses involved in, or associated with, gastroenterology and/or endoscopy nursing practice	$105.00	$60.00
☐ Voting	Associate	Limited to Assistive Personnel - technicians, technologists, assistants involved in, or associated with, gastroenterology and/or endoscopy nursing practice	$105.00	$60.00
☐ Non-Voting	Affiliate	Includes, but is not limited to, physicians, consultants, industry representatives, educators involved in, or associated with, gastroenterology and/or endoscopy nursing practice	$90.00	$45.00

SUBTOTAL A _____

B. Regional Societies

All voting members (licensed nurses and associates) residing in the U.S. are required to affiliate with an SGNA regional society.

Regional Society preference (Indicate two-digit code of preferred region from the table listed on opposite page.): _____

Regional Society Dues:

Voting Licensed Nurses and Associates
No additional payment needed
Included in Annual Dues Amount

Non-Voting Affiliate
Optional payment, if interested
please indicate preferred region above
and remit an additional $15.00
(If after July 1, remit $7.50.)

SUBTOTAL B (If applicable):_____

Canadian Society of Gastroenterology Nurses & Associates

27 Nicholson Dr., Lakeside, Nova Scotia B3T 1B3

MEMBERSHIP APPLICATION

(CHECK ONE)

☐ ACTIVE
$40.00

Open to nurses or other health care professionals engaged in full- or part-time gastroenterology and endoscopy procedure in supervisory, teaching, research, clinical or administrative capacities.

☐ AFFILIATE
$40.00

Open to physicians active in gastroenterology/endoscopy, or persons engaged in any activities relevant to gastroenterology/endoscopy (includes commercial representatives on an **individual** basis).

☐ LIFETIME MEMBERSHIP

Appointed by CSGNA Executive.

FORMULE D'APPLICATION

(COCHEZ UN)

☐ ACTIVE
40,00$

Ouvert aux infirmières et autres membres de la santé engagés à plein ou demi-temps en gastroentérologie ou procédure endoscopique en temps que superviseurs, engeignants, recherches application clinique ou administrative.

☐ AFFILIÉE
40,00$

Ouvert aux médecins, actifs en gastroentérologie endoscopique ou personnes engagés en activités en gastroentérologie/endoscopiques incluant représentants de compagnies sur une base individuelle.

☐ MEMBRE
À VIE

Appointed by CSGNA Executive.

APPLICANT INFORMATION / INFORMATION DU MEMBRE

Please print or type the following information / S.V.P. imprinter ou dactylographier l'information

SURNAME
NOM DE FAMILLE _____ PRÉNOM
FIRST NAME _____

☐ MR / M ☐ MRS / MME ☐ MISS / MLLE ☐ MS / MS

HOME ADDRESS
ADRESSE MAISON _____

CITY
VILLE _____ PROV.
PROV. _____ POSTAL CODE
CODE POSTAL _____ HOME PHONE
TÉLÉPHONE ( ) _____

HOSPITAL/OFFICE/COMPANY NAME
NOM DE HÔPITAL/BUREAU/COMPAGNIE _____

TITLE / POSITION _____

BUSINESS ADDRESS / ADRESSE TRAVAIL _____

CITY
VILLE _____ PROV.
PROV. _____ POSTAL CODE
CODE POSTAL _____

BUSINESS PHONE
TÉLÉPHONE TRAVAIL ( ) _____ EXT.
LOCAL _____ FAX
TÉLÉCOP. ( ) _____

CHAPTER NAME
NOM DU CHAPITRE _____ TITLE
POSITION _____

SEND MAIL TO (CHECK ONE) ☐ HOME ☐ BUSINESS ENVOYEZ COURRIER À (COCHEZ UNE) ☐ MAISON ☐ TRAVAIL

EDUCATION (CHECK ONE) ☐ RN ☐ RNA ☐ TECH ☐ OTHER (EXPLAIN)
ÉDUCATION (COCHEZ UN) IN I AUX TECH AUTRE (SPÉCIFIEZ) _____

MEMBERSHIP (CHECK ONE) ☐ RENEWAL ☐ NEW ABONNEMENT (COCHEZ UN) ☐ RÉNOUVELLEMENT ☐ NOUVEAU

WOULD YOU BE INTERESTED IN HELPING ON ANY OF THE FOLLOWING COMMITTEES?

- ☐ BY-LAW
- ☐ STANDARDS OF PRACTICE
- ☐ EDUCATION
- ☐ MEMBERSHIP
- ☐ CONFERENCE PLANNING
- ☐ NEWSLETTER

☐ I have enclosed my cheque payable to CSGNA. (Mail with this completed application to the above address.)

SERIEZ-VOUS INTÉRESSÉS À AIDER EN FAISANT PARTIE DE CERTAINS COMITÉS?

- ☐ BY-LAWS
- ☐ STANDARD DE PRATIQUE
- ☐ ÉDUCATION
- ☐ ABONNEMENT
- ☐ PLANIFICATION CONFÉRENCE
- ☐ JOURNAL

☐ J'ai inclus mon chéque payable à CSGNA. (Envoyez avec cette formule d'application dûment remplie à l'adresse ci-haut mentionnnée.)

CSGNA 2000-2001 Executive

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