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 master-scopes 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...
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 midday 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 anti-sepsis 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 its 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 Clarithromycin 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 nonsurgical 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 colonoscopy 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!

**BIBLIOGRAPHY**


**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 associated with cross-contamination during the procedure.

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. **Endoscopes 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.

Louise Sylvestre B.Sc.,
Clinical Advisor, Carsen Group Inc.
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 public’s 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.

All things are difficult before they are easy.
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.
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 tests 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.

**BIBLIOGRAPHY**

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 Campbell’s 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
Bourgeois-Burton Calgary, AB
Cheryl Clarke Calgary, AB
Carol Berry Edmonton, AB
Jacinta Cooke Calgary, AB
Dayna Henkelman Calgary, AB
Janina Kравcev Calgary, AB
Joan Templeman Calgary, AB
Meredit Wild Calgary, AB
Louise Wheatcroft Edmonton, AB
Shelley Bible Edmonton, AB
Pat Merriam Nepeon, ON
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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
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Diane Querin Kitchener, ON
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Starr Rohal Burlington, ON
Seta Prashad Scarborough, ON
Jean Richmond Roblin, ON
Nicolle Riverst Hearst, ON
Brenda Purcell Stratford, ON
Eileen Rideout Brampton, ON
Grace Ruhnke Peterborough, ON
Shakir Saffie Scarborough, ON
Daysi Sandino Mississauga, ON
Carolyn Saint-Yves Cambridge, 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
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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 8 1/2 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.
CANADIAN SOCIETY OF GASTROENTEROLOGY NURSES AND ASSOCIATES
CHAPTER EXECUTIVE LIST

Vancouver Regional Chapter
President: Gail Whitley
5520 Lackner Cres.
Richmond, BC V7E 6A3
(604) 875-4155 (H)
(604) 875-5391 (W)
(604) 875-5031 (Fax)
Secretary: Judy Deslippe
Treasurer: Nala Murray

Okanagan Chapter
President: Linda Frandsen
3320 Jackson Court
Kelowna, BC V1W 2T6
(250) 862-4427 (Fax)
(604) 864-4000 ext. 4427
Secretary: Arlene Schroeder
Treasurer: Debb Levine

Calgary Chapter
President: Debbie Taggart
#102 -1800 26th Ave. SW
Calgary, AB T2T 1E1
(403) 209-0217 (H)
(403) 291-8922 (W)
(403) 291-1599 (F)
Secretary: Christine Kunesky
Treasurer: Doreen Reid

Edmonton Chapter
President: Judy Langner
129 Greenooh Crescent
Edmonton, AB T6L 1W6
(780) 450-7323 (W)
(780) 450-7208 (F)
(780) 463-1934 (H)
Secretary: Doris Strudwick
Treasurer: Patti Opher

Saskatchewan Chapter
President: Elaine Fehr
195 Edenwold Cres.
Regina, SK S4R 8A6
(306) 766-2441
Secretary: Shannon Cote
Treasurer: Dianne Ryan

Manitoba Chapter
President: Sylvia Dolychnuk
1503 - 55 Nassau St. N.
Winnipeg, MB R3L 2G8
(204) 237-2249
Secretary: Roberta Thompson
Treasurer: Donna Dunsford

Ottawa Chapter
President: Michelle Paquet
2719 Wyderwood St.
St. Gloucester, ON K1T 2S1
(613) 733-1552 (H)
(613) 737-8384 (B)
Secretary: Denise Theriault
Treasurer: Monique Travers

Golden Horseshoe Chapter
President: Cindy James
220 Taylor Rd.
Ancaster, ON L9G 1P1
(905) 648-8771 (H)
(905) 521-2100 Ext. 5350 (B)
Secretary: Jennifer Belbeck
Treasurer: Sharon Thomas

South Western Ontario Chapter
President: Diane Gray
265 Jos Janisse
Windsor, ON N8Y 3A5
(519) 948-5422 (H)
(519) 254-1661 Ext 2019 (B)
Secretary: Pam Hebert
Treasurer: Joan Staddon

Vancouver Island Chapter
President: Irene Ohly
642 Caimdale Rd.
(250) 727-4234
Secretary: Pat Savage
Treasurer: Nelda Turner

London Area Chapter
President: Cheryl Parsons
401 Sunnyside Cres.
London, ON N5X 3N4
(519) 646-6000 Ext. 4355
Secretary: Lynette Elliott
Treasurer: Laura Mason

Newfoundland Chapter
President: Ellen Coady
19 Forde Dr.
St John’s, NFLD A1A 4Y1
(709) 737-6431
Secretary: June Peakham
Treasurer: Mabel Chaytor

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President: Fran Duguay
P.O. Box 973
Bathurst, NB E2A 4H8
(506) 546-4907 (H)
(506) 545-2408 (B)
Secretary/Treasurer Mary Eva Smearer

Nova Scotia Chapter
President: Elizabeth Hendsbee
284 Ross Rd.
Westphal, NS B2Z 1H2
(902) 473-6541
Secretary: Donna Cook
Treasurer: Theresa McKinnon

Greater Toronto Chapter
President: Gail Stewart
76 Yellow Birchway
Willowdale, ON M2H 2T3
(905) 491-3686 (H)
(416) 977-1600 Ext. 2033
Secretary: Elaine Burgis
Treasurer: Brenda Latch
2001:
AN EDMONTON GI ODYSSEY
SEPTEMBER 26-30, 2001
FANTASYLAND HOTEL WEST EDMONTON MALL

Patti Ofner
(780) 973-6343 (H)
(780) 477-4431 (W)
Fax: (780) 491-5739

Judy Langer
(780) 463-1934 (H)
(780) 450-7116 (W)
or (780) 450-7323
Fax: (780) 450-7208

CONTACT:
TRUST US

... we have fun!
**LithoCrush Disposable Mechanical Lithotriptor**

- Pre-Assembled
- Ready-to-use
- Reuseable handle

<table>
<thead>
<tr>
<th>Model</th>
<th>Cat. No.</th>
<th>Basket Opening (minimum)</th>
<th>Channel</th>
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<td>51686</td>
<td>26 mm</td>
<td>3.2 mm</td>
</tr>
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</table>

**ABOVE SETS INCLUDE AUTOCLAVABLE HANDLE**

BML-110A-1  51689  Emergency handle for use with above models
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 _________________
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: ______________________
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: ______________
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.

<table>
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<th>Check Membership Level/Payment</th>
<th>1 year</th>
<th>2 year</th>
<th>3 year</th>
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<td>$10</td>
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<td>$30</td>
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<td>Affiliate Membership</td>
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<td>$100</td>
<td>$150</td>
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<td>National G.E. Nursing Membership up to 100</td>
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<td>$100</td>
<td>$150</td>
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<td>101 - 400</td>
<td>$200</td>
<td>$400</td>
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<td>401 - 1,000</td>
<td>$400</td>
<td>$800</td>
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<tr>
<td></td>
<td>Over 1,000</td>
<td>$750</td>
<td>$1,500</td>
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<tr>
<td>Corporate Membership</td>
<td>$1,000</td>
<td>$2,000</td>
<td>$3,000</td>
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</tbody>
</table>

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

<table>
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<th>Year</th>
<th>Count</th>
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<tr>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

First Name (Given Name)

Last Name (Family Name)

Address for Mail

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

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
Fax

PROFESSIONAL PROFILE (Check one)

1.) Professional Setting
☐ Free Standing/Ambulatory
☐ GI Clinic
☐ Inpatient/Outpatient Combination
☐ Other

☐ Equipment Sales
☐ GI Nursing Floor
☐ Outpatient Only
☐ Manufacture
☐ Physicians Office
☐ Other

2.) Position
☐ Administrative/Director
☐ Consultant
☐ Head Nurse
☐ Supervisor/Coordinator
☐ Other

☐ Clinical Specialist
☐ Educator
☐ Researcher
☐ Nurse Practitioner
☐ Sales

☐ Technician (machine)

3.) Memberships in Other Nursing Organizations
☐ ANA/SNA
☐ AACN
☐ FNA
☐ ASPAN
☐ 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:

<table>
<thead>
<tr>
<th>Voting Status</th>
<th>Type</th>
<th>Definition</th>
<th>Annual Dues</th>
<th>Prorated Dues</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Voting</td>
<td>Licensed Nurse</td>
<td>Limited to Registered Nurses and Licensed Vocational/Practical Nurses involved in, or associated with, gastroenterology and/or endoscopy nursing practice</td>
<td>$105.00</td>
<td>$60.00</td>
</tr>
<tr>
<td>☐ Voting</td>
<td>Associate</td>
<td>Limited to Assistive Personnel, technicians, technologists, assistants involved in, or associated with, gastroenterology and/or endoscopy nursing practice</td>
<td>$105.00</td>
<td>$60.00</td>
</tr>
<tr>
<td>☐ Non-Voting</td>
<td>Affiliate</td>
<td>Includes, but is not limited to, physicians, consultants, industry representatives, educators involved in, or associated with, gastroenterology and/or endoscopy nursing practice</td>
<td>$90.00</td>
<td>$45.00</td>
</tr>
</tbody>
</table>

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 $750.)

SUBTOTAL B (If applicable):___________
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

(COCHÉZ 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, enseignants, 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. imprimer ou dactylographier l’information

SURNAME
PRENOM
MR / M
MRS / MME
MISS / MLLE
MS / MS
M. / M.
MME / MME
MLLE / MLLE
MS / MS

HOME ADDRESS
ADRESSE MAISON

CITY
VILLE

PROV.
PROV.

POSTAL CODE
CODE POSTAL

HOME PHONE
TELEPHONE

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
TELEPHONE TRAVAIL ( ), EXT. LOCAL TELECOP. (

CHAPTER NAME
NOM DU CHAPITRE

SEND MAIL TO (CHECK ONE)
☐ HOME
☐ BUSINESS
☐ MAISON
☐ TRAVAIL

EDUCATION (CHECK ONE)
☐ RN
☐ RNA
☐ TECH
☐ OTHER (EXPLAIN)

EDUCATION (COCHÉZ UN)
☐ IN
☐ I AUX
☐ TECH

MEMBERSHIP (CHECK ONE)
☐ RENEWAL
☐ NEW

ABONNEMENT (COCHÉZ UN)
☐ RÉNOUVELLEMENT
☐ NOUVEAU

WOULD YOU BE INTERESTED IN HELPING ON ANY OF THE FOLLOWING COMMITTEES?
☐ BY-LAWS
☐ 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
☐ STANDARDS 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 mentionnée.)
CSGNA 2000-2001 Executive

**PRESIDENT**

LORRAINE MILLER HAMLYN
180 Waterford Br. Rd.
St. John’s, Newfoundland
A1E 1E2
(709) 722-0294 (H)
(709) 778-6737 (W)
E-MAIL: radica2@attglobal.net
FAX: (709) 722-0294

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(416) 480-4005 (W)
FAX: (416) 480-6762
E-MAIL: malrec@hotmail.com

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Regina, Saskatchewan
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(306) 766-2762 (W)
FAX: (306) 766-2513
E-MAIL: lmcgeough@reginahealth.sk.ca

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Markham, Ontario
L3P 7N4
(905) 294-3378 (H)
(905) 472-7036 (W)
FAX: (905) 472-7086
E-MAIL: cbinger@look.ca

**CANADA EAST DIRECTORS**

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