2016-2017 MEMBERSHIP APPLICATION

Please complete all information. May be photocopied for distribution. Do not staple or tape payment to application.

JOIN NSNA ONLINE! Just go to *www.nsna.org* and click on MEMBER SERVICES

Applicant's Certification: I am eligible for and am applying for NSNA membership. **I am currently enrolled in Nursing School and have paid tuition.** I authorize NSNA to request documentation from the nursing registrar and nursing program to verify my enrollment status. I certify that all statements made in this application are complete and accurate. I understand that falsifications in my application will disqualify my application and that failure to follow all instructions on this application will render my application incomplete. Incomplete applications will not be processed.

SIGNATURE: _____ Date: _____

Dues Option: ❑ New Member ❑ Two-Year Member ❑ Renewal - NSNA Member # _____

(See dues schedule on page 6) ***The following information is very important. It will be used to prepare your mailing label for Imprint. Please print.***

First Name Last Name

Mailing Address (Do Not Abbreviate)

City State Zip

Preferred Phone Number : ( ) — —

Primary Email (required): _____

Alternate Email (optional): _____

(Print clearly and differentiate between the L; the number 1; the letter O; and zero (Ø)

NSNA policy requires that you provide your e-mail address (and alternate email address only if it is different from primary email). See the NSNA Privacy Policy on ***www.nsna.org*** and click on the membership tab.

Full Name of School (Do Not Abbreviate)

Campus & Location

School City/State

Gender: ❑ M ❑ F Expected Date of Graduation (Month): _____ (Year) _____

Type of program (Check one): ❑ Associate Degree ❑ Diploma ❑ Baccalaureate Pre-licensure ❑ RN to BSN ❑ Master's Degree Pre-licensure

How did you hear about NSNA? ❑ Student ❑ Dean/Faculty ❑ *Imprint*® ❑ NSNA Website

❑ NSNA Partnership Program: *Check if you would like additional information from participating partners (see pg 5).*

Project InTouch Recruiter #: _____

Optional - Please complete the following additional questions which will be used for statistical purposes and to help NSNA provide better service and products.

Date of Birth (Month/Day /Year): _____

Race: ❑ Black or African American ❑ American Indian or Alaska Native ❑ Asian ❑ Hispanic or Latino ❑ Native Hawaiian or other Pacific Islander ❑ Mixed Race ❑ Caucasian ❑ Other _____

❑ Amount from Dues Schedule: $_____

❑ Foundation Contribution: $_____

Total: $_____

Are you currently? (Check all that apply):

❑ Pre-nursing student (taking courses to qualify to enter nursing program) ❑ Licensed Practical/Vocational Nurse ❑ Registered Nurse ❑ Second career student ❑ Attend accelerated pre-licensure program

❑ School Chapter President (Check if you are the school chapter president.)

Method of Payment: ❑ Check ❑ Money Order ❑ MasterCard ❑ Visa

Credit Card No.: _____ Expiration Date: (Month) _____ (Year) _____

Billing Address: _____ State: _____ Zip : _____

Signature: _____ Print Name: _____

Mail the completed application form, check, credit card information or money order made out to National Student Nurses' Association, to: National Student Nurses' Association, Box 789, Wilmington, Ohio 45177 or for credit card payment only you may fax form to (937) 383-4511