



NATIONAL ASSOCIATION OF HISPANIC NURSES

Promoting Hispanic Nurses to Improve the Health of Our Communities

Membership Application and Change of Information Form

FORM SUBMISSION IS FOR:

New Membership Membership Renewal (ID Number) _____ Changes/Updates to your membership (no payment necessary)

NATIONAL MEMBERSHIP CATEGORIES & CRITERIA

Full* For Hispanic/Latino/a nurses licensed in the US and its jurisdictions
Associate Non-Hispanic/Latino/a US-licenses nurses interested in solving problems/needs of Hispanic/Latino/a community
Affiliate For non-nursing health care professionals interested in solving problems/needs of Hispanic/Latino/a nurses
International Licensed Hispanic/Latino/a nurses licensed not residing in the US or its jurisdictions
Retired* For Hispanic/Latino/a US-licensed nurses 62 years or older who are not employed full-time in nursing
Student **PROOF REQUIRED (current transcript + or letter from nursing program) For Hispanic/Latino/a students enrolled in a RN, LPN/LVN program leading to licensure**
**Full (Active) and Retired are the only categories with voting privileges. +Transcript may be obtained from school's website*

Membership Category	National Membership with Chapter Membership		National Membership only (no chapter)
	<input type="checkbox"/> \$100 (One Year)	<input type="checkbox"/> \$175 (Two Year)	<input type="checkbox"/> \$75
Full	<input type="checkbox"/> \$100 (One Year)	<input type="checkbox"/> \$175 (Two Year)	<input type="checkbox"/> \$75
Associate	<input type="checkbox"/> \$75		<input type="checkbox"/> \$50
Affiliate	<input type="checkbox"/> \$75		<input type="checkbox"/> \$50
International	<input type="checkbox"/> \$75		<input type="checkbox"/> \$50
Retired	<input type="checkbox"/> \$65		<input type="checkbox"/> \$50
Student	<input type="checkbox"/> \$40		<input type="checkbox"/> \$30
Corporate	<input type="checkbox"/> N/A		<input type="checkbox"/> \$5,000

Name: *First* _____ *Middle* _____ *Last* _____ Credentials: _____
 Home Address: _____ Apt. _____
 City: _____ State: _____ Zip: _____ Country: _____
 Home Phone: _____ Cell Phone: _____ Home E-mail: _____
RN/LPN/LVN License # _____ **Issuing State:** _____ **Expiration Date:** _____
 Employer: _____ Position/Title: _____
 Work Address: _____ Suite: _____
 City: _____ State: _____ Zip: _____ Country: _____
 Work Phone: _____ Work Fax: _____ Work E-Mail: _____

Please sign and return this form along with any other required documentation and your remittance.

All membership applications must be signed below to comply with postal regulations.

I certify I am eligible for the membership I have selected and fully meet the criteria.

Signature: _____ Date: _____

METHOD OF PAYMENT

Visa MasterCard American Express
 Check or Money Order made payable to NAHN (Return check fee is \$35)

Card No.: _____ Expiration Date: _____
 Cardholder's Name: _____ CVC #: _____
 (CVC #: AX 4 digits front of card & MC/ Visa 3 digits back of card)
 Signature: _____

AMOUNT ENCLOSED

Membership Dues:
 National With Chapter \$ _____
 National Only \$ _____
 Annual Fund Contribution: (optional) \$ _____
 Scholarship Fund Contribution: (optional) \$ _____
Total Enclosed: \$ _____

LOCAL CHAPTERS*

*National membership is required to join a chapter

LOCAL CHAPTER SELECTION: _____

ARIZONA Yuma (Angeles del Deserto) Tucson Phoenix (Valle del Sol)	SAN JOAQUIN VALLEY COLORADO Denver DELAWARE Delaware	INDIANA Central Northwest	NEVADA Las Vegas	RHODE ISLAND Ocean State
ARKANSAS Arkansas	DISTRICT OF COLUMBIA Washington DC	KENTUCKY Kentucky	NEW JERSEY New Jersey	TEXAS Brownsville Corpus Christi Dallas Houston Lubbock
CALIFORNIA Greater San Jose Imperial Valley Los Angeles Orange County San Bernadino (Inland Empire) San Diego San Francisco Bay Area	FLORIDA Broward County Greater Orlando Miami GEORGIA Atlanta Savannah ILLINOIS	MASSACHUSETTS Massachusetts MICHIGAN Michigan MISSOURI Kansas City (Corazon de la Tierra) NEBRASKA Nebraska	NEW YORK New York NORTH CAROLINA North Carolina OREGON Portland PENNSYLVANIA Philadelphia PUERTO RICO Puerto Rico	WASHINGTON Eastern Washington WISCONSIN Southeastern WI

MEMBER AMBASSADOR

Referred by: _____ Membership ID: _____

Please visit the NAHN website for information on the Member Ambassador Program

STUDENT PROFILE:
(Required with Student Application)

School Name: _____

Program Name: _____

RN Student

Anticipated Graduation Year _____

LPN/LVN Student

Anticipated Graduation Year _____

Other (*specify*): _____

HIGHEST DEGREE EARNED:

Doctorate (*Nursing*)

(*specify*): _____

Doctorate (*non-Nursing*)

(*specify*): _____

Masters (*Nursing*)

(*specify*): _____

Masters (*non-Nursing*)

(*specify*): _____

Baccalaureate

Associate

Diploma

Voc-Tech

RACIAL / ETHNIC BACKGROUND:

Hispanic / Latino / Latina

African American

White

Asian American

Native American

Other

Only FULL MEMBERSHIP or
RETIRED MEMBERSHIP of HISPANIC,
LATINO, or LATINA Heritage have voting rights.

ADDITIONAL CHAPTER

If you wish to add an additional chapter, please
note chapter name: _____

STUDENTS add \$10 (to Membership Fees)

ALL OTHERS add \$25 (to Membership Fees)

No