



The School Nurses Organization of Arizona

Please complete this document and attach your check to SNOA for Membership to our state organization. This does not include NASN. If you are a member of NASN you are a member of SNOA.

Name: _____ Date: _____

Home Address: _____

Home Phone: _____ Cell: _____

Home email: _____

Name of School District: _____

Address of District: _____

Contact Phone: _____

Contact email: _____

SNOA Membership Rates:

RN: \$35.00/year I wish to become a member of SNOA _____

LPN: \$30.00/year I wish to become a member of SNOA _____

UAP: \$25.00/year I wish to become a member of SNOA _____

Affiliate: \$20.00/year I wish to become a member of SNOA _____

Would you like to participate in a SNOA Committee to improve support for school health offices in Arizona? (Circle all interests) 1. Conference committee. 2. Legislative Committee 3. School Health Training/Planning Committee 4. Webpage Committee 5. Other _____

Mail to: 4650 E. Cotton Center Blvd., Ste. 155, Phoenix, AZ, 85040