



# San Antonio Indian Nurses Association

P.O. Box # 29841  
www.sainausa.com  
sainausa@sainausa.com

## Membership Application Form

Application Date: \_\_\_\_\_ File Number (Official Use Only): \_\_\_\_\_

Membership Type (One Year Term):  Active Member(\$30)  Associate Member(\$25)  
 Affiliate Member(\$25)  Student Member(\$20)  Retired Nurse Member(\$20)  
 Best value Member (10 year Term) (\$200)

Name: \_\_\_\_\_  
Last Name First Name MI

Address: \_\_\_\_\_  
Number/ Street Name City State Zip Code

Phone Number: (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Home Cell Work

E-mail Address: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

Position: \_\_\_\_\_ Area of Specialty: \_\_\_\_\_

Basic School/ College of Nursing Attended: \_\_\_\_\_

Ethnicity:  Asian Indian  Asian Indian descent  Other (please specify) \_\_\_\_\_

Highest Degree of Education:  Diploma  BSN  BS  MS  MSN  Doctorate  MBA

Please contact Malathi Balraj at Malthi.Balraj@uhs-sa.com for Membership questions. Your signature below indicates that you are hereby agreeing to the terms and will uphold the mission, vision and bylaws of SAINA. Please return the completed form along with a check for appropriate fees.

Make the check payable to SAINA and mail to: Jai Thomas, 7818 Lacey Oak Cove, San Antonio, TX 78250

Signature of the Prospective Member: \_\_\_\_\_ Date: \_\_\_\_\_

OFFICIAL USE ONLY Application/Fee Received On : \_\_\_\_\_ Membership Approved: Yes \_\_\_ No \_\_\_

\_\_\_\_\_  
Name of the official

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date