



Individual Membership Application with Check Payment

Thanks for your interest in the National Association of Hispanic Nurses (NAHN). Please select the applicable membership type and mail this completed form with check payment to NAHN, PO Box 501, Lexington, KY 40588. For details on the membership categories or to apply online and pay by credit card, scan the QR code or visit this link:

<https://www.nahnnet.org/membership/join/member-benefits>



Membership Category	National Membership with Chapter Membership	National Membership only (no chapter)
General (licensed nurse practicing in U.S. and its jurisdictions)	<input type="checkbox"/> \$125 (One Year) <input type="checkbox"/> \$225 (Two Year)	<input type="checkbox"/> \$100 (One Year) <input type="checkbox"/> \$175 (Two Year)
Nursing Affiliate (CNA, Med Assistant, etc.)	<input type="checkbox"/> \$40	<input type="checkbox"/> \$30
International Associate (non-U.S. nurse)	<input type="checkbox"/> \$100	<input type="checkbox"/> \$75
Student (unlicensed, enrolled in RN or LPN/LVN program)	<input type="checkbox"/> \$50	<input type="checkbox"/> \$30
Emeritus (retired nurse)	<input type="checkbox"/> \$90	<input type="checkbox"/> \$75
Affiliate (other)	<input type="checkbox"/> \$100	<input type="checkbox"/> \$75

NOTE: General (Active) and Emeritus are the only category with voting privileges.

Select Your Chapter (if applicable)

- | | | |
|------------------------------------------------------|-------------------------------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> ALABAMA | <input type="checkbox"/> FLORIDA | <input type="checkbox"/> OHIO |
| | <input type="checkbox"/> Broward County | <input type="checkbox"/> Greater Cincinnati |
| <input type="checkbox"/> ARIZONA | <input type="checkbox"/> Greater Orlando | <input type="checkbox"/> Northeast Ohio |
| <input type="checkbox"/> Angeles del Desierto (Yuma) | <input type="checkbox"/> Miami | |
| <input type="checkbox"/> Phoenix | <input type="checkbox"/> West Florida Chapter | <input type="checkbox"/> OREGON/Portland |
| <input type="checkbox"/> CALIFORNIA | <input type="checkbox"/> GEORGIA | <input type="checkbox"/> PENNSYLVANIA |
| <input type="checkbox"/> Inland Empire (Riverside) | <input type="checkbox"/> ILLINOIS | <input type="checkbox"/> Philadelphia |
| <input type="checkbox"/> Los Angeles | <input type="checkbox"/> INDIANA | <input type="checkbox"/> Pittsburgh (Western PA) |
| <input type="checkbox"/> Orange County | <input type="checkbox"/> MASSACHUSETTS | <input type="checkbox"/> TENNESSEE |
| <input type="checkbox"/> Sacramento | | |
| <input type="checkbox"/> San Diego | <input type="checkbox"/> MICHIGAN | <input type="checkbox"/> TEXAS |
| <input type="checkbox"/> San Francisco Area | <input type="checkbox"/> Michigan | <input type="checkbox"/> Austin |
| <input type="checkbox"/> COLORADO | <input type="checkbox"/> Capital Area Michigan | <input type="checkbox"/> Brownsville |
| <input type="checkbox"/> Denver | | <input type="checkbox"/> Corpus Christi |
| <input type="checkbox"/> Southern Colorado | <input type="checkbox"/> MISSOURI (El Corazon de la Tierra/Kansas City) | <input type="checkbox"/> Dallas |
| <input type="checkbox"/> CONNECTICUT | <input type="checkbox"/> NEBRASKA | <input type="checkbox"/> El Paso |
| <input type="checkbox"/> Connecticut | <input type="checkbox"/> NEVADA | <input type="checkbox"/> Houston |
| <input type="checkbox"/> Hartford | <input type="checkbox"/> NEW JERSEY | <input type="checkbox"/> San Antonio |
| <input type="checkbox"/> DELAWARE | | |
| | <input type="checkbox"/> NEW YORK | <input type="checkbox"/> UTAH |
| | <input type="checkbox"/> New York | <input type="checkbox"/> WASHINGTON DC |
| | <input type="checkbox"/> Westchester County | <input type="checkbox"/> WISCONSIN |

MEMBER INFORMATION (Please print legibly and complete all applicable fields)

First Name _____ Middle _____

Last Name _____

Credentials: RN BSN MSN DNP PhD FAAN Other _____

Home Address _____

City _____

State _____ ZIP Code _____

Home Phone _____

Cell Phone _____

Primary Email (will be your member log in) _____

RN/LPN/LVN License # _____

Issuing State _____ Expiration Date _____

Employer _____

Position/Title _____

City _____ State _____

My submission of this form, I agree to comply with NAHN policies and understand that my membership in NAHN is conditioned on payment of annual dues. I will notify NAHN headquarters of any changes in my status (student to employed nurse, for example) and my contact details.

Signature _____ Date _____

MEMBER AMBASSADOR: I was referred by _____

Please return this form with your check payment to **NAHN, PO Box 501, Lexington, KY 40588**. A \$35 fee will apply for returned checks. Membership dues are nonrefundable.

National With Chapter \$ _____ -or- National Only \$ _____

*Annual Fund Contribution \$ _____

Total Enclosed \$ _____

**Donations to the Annual Fund are optional and are tax deductible to the extent allowed; check with your tax professional. Donations are used to further educational, research and scholarship opportunities. NAHN is a 501(c)(3) nonprofit organization. EIN: 91-1010677*