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)	❑ $125 (One Year) ❑ $225 (Two Year)	❑ $100 (One Year) ❑ $175 (Two Year)
Nursing Affiliate (CNA, Med Assistant, etc.)	❑ $40	❑ $30
International Associate (non-U.S. nurse)	❑ $100	❑ $75
Student (unlicensed, enrolled in RN or LPN/LVN program)	❑ $50	❑ $40
Emeritus (retired nurse)	❑ $90	❑ $75
Affiliate (other)	❑ $100	❑ $75

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

Select Your Chapter (if applicable)

❑ ALABAMA

ARIZONA
❑ Angeles del Desierto (Yuma)
❑ Phoenix

CALIFORNIA
❑ Inland Empire (Riverside)
❑ Los Angeles
❑ Orange County
❑ Sacramento
❑ San Diego
❑ San Francisco Area

COLORADO
❑ Denver
❑ Southern Colorado

CONNECTICUT
❑ Connecticut
❑ Hartford

FLORIDA
❑ Broward County
❑ Central Florida Chapter
❑ Greater Orlando
❑ Miami
❑ West Florida Chapter

❑ GEORGIA
❑ ILLINOIS
❑ INDIANA
❑ MASSACHUSETTS
❑ MICHIGAN
❑ MISSOURI (El Corazon de la Tierra/Kansas City)
❑ NEBRASKA
❑ NEVADA
❑ NEW JERSEY

NEW YORK
❑ New York
❑ Westchester County

OHIO
❑ Greater Cincinnati
❑ Northeast Ohio

❑ OREGON/Portland

PENNSYLVANIA
❑ Philadelphia
❑ Pittsburgh (Western PA)
❑ TENNESSEE
TEXAS
❑ Austin
❑ Brownsville
❑ Corpus Christi
❑ Dallas
❑ El Paso
❑ Houston
❑ San Antonio
❑ UTAH
❑ WASHINGTON (State)
❑ WASHINGTON DC
❑ 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 extend 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*