

Completed applications should be mailed with payment to:

|  |  |  |  |  |
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| **MEMBERSHIP APPLICATION** | [www.phnurse.org](http://www.phnurse.org)  | APHN | 110A Northwoods Blvd | Columbus, OH 43235 |

**CONTACT INFORMATION**

FIRST NAME LAST NAME CREDENTIALS

TITLE LICENSE # STATE ISSUED

ORGAJNIZATION/AGENCY AFFILIATION

ADDRESS

CITY STATE ZIP CODE

BUSINESS PHONE

E-MAIL ADDRES

**MEMBERSHIP TYPE**

[ ]  $400.00 – **Official State or Territorial Representative**

A registered nurse who serves as the State/Territorial Nursing Director or is designated as the official representative by the State/Territorial Health Official of that jurisdiction

[ ]  $125.00 – **Public Health Nurse**

A public health nurse who works in the field of public health including, but not limited to, those working in a local, state, or federal governmental public health agency or department, school health, higher education and community based nursing, but who is not the Official State or Territory Representative

[ ]  $200.00 – **Public Health Nurse Contributing Member**

A public health nurse who desires to support the operation of the organization through a contribution.

[ ]  $125.00 – **Retired Public Health Nurse**

 A retired, registered nurse who formerly served as a public health nurse in any capacity in the field of public health

The above incumbents are full members with all privileges including voting, holding office, and service on committees.

[ ]  $75.00 – **Public Health Worker or Individual with Interest in Public Health**

An individual working in the field of public health, or with an interest in public health.

[ ]  $75.00 – **Retiree (from all work)**

 A retired, registered nurse who formerly served as a public health nurse in any capacity in the field of public health

[ ]  $30.00 – **Student**

A pre-professional student enrolled in an academic program.

The above incumbents are members with voting privileges and service on committees but may not hold office.

[ ]  **Donate**

 I would like to donate \_\_\_\_\_\_\_\_\_ to the mission and purposes of APHN.

|  |  |  |
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| **TOTAL:** | $ |  |

[ ]  “I certify that I meet all the membership qualifications required for the membership type that I have selected above. If I checked one of the first 4 membership types set forth above, I certify that I am a registered nurse in good standing without encumbrance or disciplinary action. For all membership types, I support the mission and purposes of APHN.”