2015-2016 MEMBERSHIP APPLICATION

Please complete all information. May be photocopied for distribution. Do not staple or tape payment to application. JOIN NSNA ONLINE! Just go to www.nsna.org and click on MEMBER SERVICES.

Applicant's Certification: I am eligible for and am applying for NSNA membership. I am currently enrolled in Nursing School and have paid tuition. I authorize NSNA to request documentation from the nursing registrar and nursing program to verify my enrollment status. I certify that all statements made in this application are complete and accurate. I understand that falsifications in my application will disqualify my application and that failure to follow all instructions on this application will render my application incomplete. Incomplete applications will not be processed.

SIGNATURE: __________________________ Date: __________________________

Dues Option: □ New Member  □ Two-Year Member  □ Renewal - NSNA Member # __________

(See dues schedule on page 6) The following information is very important. It will be used to prepare your mailing label for Imprint. Please print.

First Name __________________________ Last Name __________________________

Mailing Address (Do Not Abbreviate)

Street __________________________ Street __________________________

City __________________________ State __________________________ Zip __________________________

Preferred Phone Number: (_____)(_____)(____) __________________________

Primary Email (required):

Alternate Email (optional):

(Print clearly and differentiate between the L, the number 1, the letter O; and zero 0)

NSNA policy requires that you provide your e-mail address. See the NSNA Privacy Policy on www.nsna.org and click on the membership tab.

Full Name of School (Do Not Abbreviate)

LOUISIANA STATE UNIVERSITY

HEALTH SCIENCES CENTER

NEW ORLEANS, LOUISIANA

Gender: □ M  □ F  Expected Date of Graduation (Month): __________ (Year): __________

Type of program (Check one): □ Associate Degree  □ Diploma  □ Bachelor's Pre-Licensure

□ RN to BSN  □ Master's Degree Pre-Licensure

□ NSNA Partnership Program: Check if you would like additional information from participating partners (see pg 5): Project InTouch Recruiter #: __________________________

Optional - Please complete the following additional questions which will be used for statistical purposes and to help NSNA provide better service and products.

Date of Birth (Month/Day/Year): __________________________

Race: □ Black or African American  □ American Indian or Alaska Native

□ Asian  □ Hispanic or Latino

□ Native Hawaiian or other Pacific Islander  □ Mixed Race  □ Caucasian  □ Other

□ Amount from Dues Schedule: $ __________ Are you currently? (Check all that apply):

□ Foundation Contribution: $ __________ □ Pre-nursing student (taking courses to qualify to enter nursing program)

□ Total: $ __________ □ Licensed Practical/Vocational Nurse

□ School Chapter President: (Check if you are the school chapter president.)

□ Method of Payment: □ Check  □ Money Order  □ MasterCard □ Visa  □

Credit Card No. __________________________ Exp. Date (Month): __________________________

Billing Address: __________________________ State: __________________________ Zip: __________________________

Signature: __________________________ Print Name: __________________________

Mail the completed application form, check, credit card information or money order made out to National Student Nurses' Association, Inc., National Student Nurses' Association, Box 789, Wilmington, Ohio 45177 or for credit card payment only you may fax form to (937) 383-4511.