2013-2014 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 4)

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)

City: ___________________________ State: ___________ Zip: ___________

Preferred Phone Number: ___________________________

E-mail: ___________________________

Permanent E-mail Address: ___________________________

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

Full Name of School (Do Not Abbreviate)

L O U I S I A N A S T A T E U N I V E R S I T Y

Campus & Location

HEALTH SCIENCES CENTER

School City/State

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 Pre-licensure ☐ Doctorate Pre-licensure

How did you hear about NSNA?

☐ Student ☐ Dean/Faculty ☐ Imprint* ☐ NSNA Website

Project InTouch Recruiter #: ___________________________

☐ NSNA Partnership Program: Check if you would like additional information

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): ☐ Pre-nursing student (taking courses to qualify to enter nursing program) ☐ Licensed Practical/Vocational Nurse

☐ Registered Nurse ☐ Second career student ☐ Attend accelerated pre-licensure program

☐ Foundation Contribution: $_____________ Total: $_____________

NSNA Leaders: if you hold a leadership position please check all applicable categories

Chapter Level: ☐ School Chapter President

☐ Men’s/Lesbian Chair ☐ Vice-Presidents (VP) First and Second VP ☐ Community Health Chair ☐ Newsletter/Website Editor

☐ Public Relations Chair ☐ Breakthrough to Nursing* Chair ☐ Bylaws Chair ☐ Treasurer

☐ Nominations Chair ☐ Image of Nursing Chair ☐ Legislation/Education Chair ☐ Secretary

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

Credit Card No: ___________________________ Expiration Date: (Month): ___________ (Year): ___________

Signature: ___________________________ Print Name: ___________________________

Mail the completed application form, check or money order made out to National Student Nurses’ Association, or credit card information to:
National Student Nurses’ Association, Box 789, Wilmington, Ohio 45177 or for credit card payment only you may fax form to (937) 393-4511

Check or Cash Only