



STATE NURSES ASSOCIATION MEMBERSHIP APPLICATION

8515 Georgia Avenue • Suite 400 • Silver Spring, MD 20910-3492 • (301) 628-5180 • Fax: (301) 628-5355

Date: ___/___/___ Date of Birth: ___/___/___

Mailing Address

E-mail

First Name/MI/Last Name

Mailing Address

Employment Status: (ie. full-time nurse)

Credentials

City/ST/Zip

Position Title: (ie. staff nurse)

Home Phone Number Work Phone Number

County

Type of Work Setting: (ie. hospital)

Employer

RN License # _____ ST _____

Practice Area: (ie. pediatrics)

Preferred Contact: **HOME/WORK** • Gender: **M/F**

Union Member: **YES/NO** • UAN Member: **YES/NO**

MEMBERSHIP DUES VARY BY STATE

[Check with your Constituent Member (State) Nurses Association for rates, or call 1-800-923-7709 from 9 am to 5 pm EST Monday to Friday.]

Membership Category (check one)

M Full Membership Dues

- Employed - Full Time
- Employed - Part Time

R Reduced Membership Dues

- Not Employed
- Full Time Student
- New graduate from basic nursing education program, within six months after graduation (first membership year only)
- 62 years of age or over and not earning more than Social Security allows

S Special Membership Dues

- 62 years of age or over and not employed
- Totally Disabled

Choice of Payment (please check)

E-Pay (Monthly Electronic Payment)

This is to authorize monthly electronic payments to American Nurses Association, Inc. (ANA). By signing on the line, I authorize my Constituent Member Association (CMA)/ANA to withdraw 1/12 of my annual dues and any additional service fees from my account.

- Checking:** Please enclose a check for the first month's payment; the account designated by the enclosed check will be drafted on or after the 15th of each month.
- Credit Card:** Please complete the credit card information below and this credit card will be debited on or after the 1st day of each month.

Full Annual Payment

Membership Investment _____
ANA-PAC (Optional — \$20 suggested) _____
Total Dues and Contributions _____

Online: www.NursingWorld.org (Credit Card Only)

- Check (payable to ANA)
- VISA
- MasterCard

Payroll Deduction

This payment plan is available only where there is an agreement between your employer and the association to make such deduction.

Signature for Payroll Deduction

Please mail your completed application with payment to your **STATE NURSES ASSOCIATION** or to:

AMERICAN NURSES ASSOCIATION
Customer and Member Billing
P.O. Box 504345
St. Louis, MO 63150-4345

* NOTE:

By signing the Monthly Electronic Deduction Authorization, or the Automatic Annual Credit Card Payment Authorization, you are authorizing ANA to change the amount by giving the above-signed thirty (30) days advance written notice. Abovesigned may cancel this authorization upon receipt by ANA of written notification of termination twenty (20) days prior to deduction date designated above. Membership will continue unless this notification is received. ANA will charge a \$5 fee for any returned drafts or chargebacks.

SUBSCRIPTIONS:

\$5.42 of the CMA member dues is for a subscription to *The American Nurse* and \$20 is for a subscription to *American Nurse Today*. Various amounts are for subscriptions to CMA/DNA newsletters. Check with your CMA office for exact amount.

BUSINESS EXPENSE:

State nurses association dues are not deductible as charitable contributions for tax purposes, but may be deductible as a business expense. However, the percentage of dues used for lobbying by the CMA is not deductible as a business expense. Please check with your CMA for the correct amount.

CREDIT CARD INFORMATION

Credit Card Number

Expiration: month/year

Security Code (cvv/cvc)

Authorization Signature

Printed Name

Amount: \$ _____

Automated Annual Credit Card Payment

This is to authorize annual credit card payments to American Nurses Association, Inc. (ANA). By signing on the line, I authorize CMA/ANA to charge the credit card listed in the credit card information section for the annual dues on the 1st day of the month when the annual renewal is due.

Monthly Electronic Deduction Authorization Signature

*SEE NOTE

Annual Credit Card Payment Authorization Signature

*SEE NOTE

TO BE COMPLETED BY SNA

Employer Code _____

STATE _____ DIST _____ REG _____

Approved By _____ Date _____

Expiration Date _____ / _____
Month Year

\$ _____
AMOUNT ENCLOSED CHECK # _____

Sponsor, if applicable _____

SNA membership # _____

M E M B E R S H I P A P P L I C A T I O N

Code: APP-08