

# Maine Nurse Practitioner Association 2010 Membership Application

RenewalDate: \_\_\_\_\_ Status: \_\_\_\_\_ New: \_\_\_\_\_ Renewal: \_\_\_\_\_

**PLEASE CAREFULLY REVIEW THE FOLLOWING INFORMATION FROM YOUR MEMBERSHIP RECORD  
AND MAKE ANY CHANGES YOU WISH. PLEASE PRINT CLEARLY.**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Credentials: \_\_\_\_\_

Home Address: \_\_\_\_\_ City/Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_ Pager: \_\_\_\_\_ Voice Mail: \_\_\_\_\_

Business Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Demographic Information: (Answers are optional but helpful in determining organizational needs and salary ranges by specialty.)**

Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Primary Specialty: \_\_\_\_\_ Adult Family Geriatrics Pediatrics Psychiatric Women's Health Other \_\_\_\_\_  
(circle one)

Certified: \_\_\_\_\_ By Whom \_\_\_\_\_ ANCC/ANA NCBPNP ACM NCC AANP Other \_\_\_\_\_

Employer: \_\_\_\_\_ Salary: \_\_\_\_\_

Private Office       Rural Clinic       Part Time <40 hrs.       Full time >40 hrs.  
 Hospital/Outpt       College Clinic  
 Hospital/Inpt       Family Planning  
 Faculty/Academic       Other \_\_\_\_\_ Town where you practice \_\_\_\_\_

If you are a student, what school are you attending? \_\_\_\_\_

What type of program? \_\_\_\_\_  Certificate  Bachelors  Masters  Other \_\_\_\_\_

**DUES ARE FOR THE PERIOD ENDING OCTOBER 1, 2010. PLEASE NOTE: WE ESTIMATE THAT 7% OF DUES WILL BE ALLOCATED  
FOR LOBBYING EFFORTS; THEREFORE, 93% OF YOUR DUES ARE TAX DEDUCTIBLE.**

Membership Type: \_\_\_\_\_

\$125.00 Full Membership       \$75.00 Associate Membership  
(non NP RNs)  
 \$40.00 Student Membership  
(NP Students)       \$125.00 Supporting Membership  
(non-nurse interested parties)  
 \$40.00 Retired/Unemployed

PAYMENT METHOD       Check Enclosed       Visa       Master Card

Name as on card: \_\_\_\_\_ Card # \_\_\_\_\_ Expires: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**MAKE CHECK PAYABLE TO MAINE NURSE PRACTITIONER ASSOCIATION.  
MAIL THE MEMBERSHIP FORM, ALONG WITH PAYMENT TO:  
MAINE NURSE PRACTITIONER ASSOCIATION, 11 COLUMBIA ST., AUGUSTA ME 04330  
Phone: (207) 621-0313 Fax: (207) 622-4437**

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## Education and Committee Information

Which of the following committees would you be able to participate in?

Professional Development    Legislative    Public Relations    Unable at this time

I am interested in serving on MNPA's Board of Directors

What educational topics would you like to see offered at future conventions ?

\_\_\_\_\_

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## Listserve Information

**IF YOU WOULD LIKE TO SUBSCRIBE TO THE MNPA LISTSERVE, PLEASE INDICATE THE EMAIL ADDRESS AND CONFIRM BY SIGNING BELOW. IF YOU DO NOT INCLUDE AN EMAIL AND SIGNATURE, YOU WILL NOT HAVE ACCESS TO THE LISTSERVE.**

**Email:** \_\_\_\_\_      **Signature:** \_\_\_\_\_

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## Directory and Website Information

From time to time, we distribute to other organizations, upon request, a mailing list of members with their home addresses to facilitate conference planning and mailings relevant to NPs. Please sign below if you wish to be included.

**Check here if you wish to have your name on this list.**

A Maine Nurse Practitioner Directory may be made available to various nursing association memberships and other interested parties to facilitate referrals, consultation and collaboration. (\*Students please wait until you are established in practice.)

**Check here if you wish to be listed in the Directory.**

**I HEREBY AUTHORIZE MAINE NURSE PRACTITIONER ASSOCIATION TO POST THE INFORMATION BELOW ABOUT ME ON ITS WEBSITE AND PUBLISH IT IN THE DIRECTORY. I UNDERSTAND THAT, FOR PRIVACY AND SECURITY REASONS, IT MAY NOT BE ADVISABLE TO INCLUDE MY HOME ADDRESS AND PHONE NUMBER. I FURTHER UNDERSTAND THAT MY NAME WILL NOT APPEAR ON THE WEBSITE OR IN THE DIRECTORY IF I DO NOT SIGN AND DATE BELOW.**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

INDICATE BELOW CONTACT INFORMATION AS YOU WISH IT TO APPEAR ON THE MNPA WEBSITE, AS WELL AS IN THE MAINE NURSES IN ADVANCED PRACTICE DIRECTORY WHICH WILL BE MADE AVAILABLE TO VARIOUS NURSING ASSOCIATION MEMBERSHIPS AND OTHER INTERESTED PARTIES TO FACILITATE REFERRALS, CONSULTATION AND COLLABORATION.

Check one or more specialties in which you are certified other than your primary specialty which is indicated on page one of your application.

Adult    Family    Geriatrics    Pediatrics    Psychiatric    Women's Health    Other \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Email: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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### For Office Use Only:

Received By: \_\_\_\_\_ Date: \_\_\_\_\_

Check #: \_\_\_\_\_ Amount: \_\_\_\_\_ File Copy Made: \_\_\_\_\_

Revised Oct 2009