

Maine Nurse Practitioner Association 2012 Membership Application

Renewal Date: _____ 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: _____ Professional Title: _____

Home Address: _____ City/Town: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Fax: _____

Email: _____

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: _____ (circle one) Adult Family Geriatrics Pediatrics Psychiatric Women's Health Other _____

Areas of Professional Interest: _____

Certifying Organization: _____ (circle one) ANCC/ANA NCBPNP ACM NCC AANP Other _____

Employer: _____ Salary: _____

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Private Office | <input type="checkbox"/> Rural Clinic | <input type="checkbox"/> Part Time <40 hrs. | <input type="checkbox"/> Full time >40 hrs. |
| <input type="checkbox"/> Hospital/Outpt | <input type="checkbox"/> College Clinic | | |
| <input type="checkbox"/> Hospital/Inpt | <input type="checkbox"/> Family Planning | | |
| <input type="checkbox"/> Faculty/Academic | <input type="checkbox"/> 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, 2012. PLEASE NOTE: WE ESTIMATE THAT 23% OF DUES WILL BE
ALLOCATED FOR LOBBYING EFFORTS; THEREFORE, 77% OF YOUR DUES ARE TAX DEDUCTIBLE.**

Membership Type: _____

- | | |
|--|--|
| <input type="checkbox"/> \$125.00 Full Membership | <input type="checkbox"/> \$75.00 Associate Membership
(non NP RNs) |
| <input type="checkbox"/> \$50.00 Student Membership
(NP Students) | <input type="checkbox"/> \$75.00 Supporting Membership
(non-nurse interested parties) |
| <input type="checkbox"/> \$40.00 Retired/Unemployed | |

PAYMENT METHOD: Check Enclosed Visa Master Card Discover American Express

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**

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 ?

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:** _____

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: _____

For Office Use Only:

Received By: _____ Date: _____

Check #: _____ Amount: _____ File Copy Made: _____

Revised Oct 2010