

ACNP Membership Application

PLEASE PRINT CLEARLY

Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Work Phone: _____ Home Phone: _____ Fax: _____

MEMBERSHIP CATEGORIES (check one):

- | | <u>One year</u> | <u>Two years</u> |
|---|-----------------|------------------|
| <input type="checkbox"/> Individual | \$110 | \$200 |
| <input type="checkbox"/> Individual w/Affiliate Discount | \$95 | \$180 |
| To qualify for the affiliate discount you must belong to an ACNP National, State, or Group Affiliate organization. See a complete list of affiliate organizations at www.acnpweb.org .
Name of ACNP Affiliate Organization: _____ Member #: _____ | | |
| <input type="checkbox"/> Student | \$55 | N/A |
| Students must submit proof of NP enrollment (i.e. copy of current schedule or letter from the program). | | |
| <input type="checkbox"/> Associate | \$50 | N/A |
- Do you have prescriptive authority?** Yes No **Do you have a DEA number?** Yes No

SPECIALTY:

Acute Care Adult Family Gerontological Pediatric Psych/Mental Health Women's Health Other: _____
(please specify)

PRACTICE SETTING (Check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> College/School Health | <input type="checkbox"/> Hospital |
| <input type="checkbox"/> College/University (faculty) | <input type="checkbox"/> Long-Term Care |
| <input type="checkbox"/> Community Health Center | <input type="checkbox"/> MD/NP Practice |
| <input type="checkbox"/> Correctional/Prison Facility | <input type="checkbox"/> Military |
| <input type="checkbox"/> Emergency Rm/Urgent Care | <input type="checkbox"/> NP Private Practice |
| <input type="checkbox"/> Employee/Occupational Hlth | <input type="checkbox"/> Psych/Mental Center |
| <input type="checkbox"/> Health Department | <input type="checkbox"/> Rural Health Clinic |
| <input type="checkbox"/> Home Health Agency | <input type="checkbox"/> Women's Health Center |
| <input type="checkbox"/> Hospice/Palliative Care | <input type="checkbox"/> Other: _____ |
- (please specify)

SUBSPECIALTY AREAS (Check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Allergy/Immunology | <input type="checkbox"/> Neurology |
| <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Orthopedics |
| <input type="checkbox"/> Dermatology | <input type="checkbox"/> Pain Management |
| <input type="checkbox"/> Endocrinology | <input type="checkbox"/> Psych/Mental Health |
| <input type="checkbox"/> Gastroenterology | <input type="checkbox"/> Respiratory/Pulmonology |
| <input type="checkbox"/> Hematology/Oncology | <input type="checkbox"/> Rheumatology |
| <input type="checkbox"/> Infectious Diseases | <input type="checkbox"/> Women's Health |
| <input type="checkbox"/> Nephrology | <input type="checkbox"/> Other: _____ |
- (please specify)

METHOD OF PAYMENT: Check (enclosed) American Express MasterCard Visa

Name (as it appears on the credit card): _____

Credit Card #: _____ Exp. Date: _____

Signature (required): _____ Date: _____

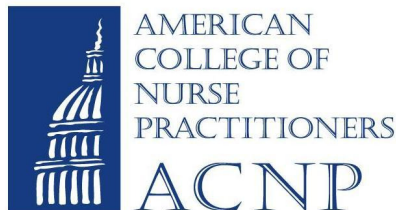
Mail completed application form to:

ACNP Membership, 1501 Wilson Boulevard, Suite 509, Arlington, VA 22209

Phone: (703) 740-2529 ext.225 Fax: (703) 740-2533

APPLY ONLINE: www.acnpweb.org

ACNP members have a significant opportunity to put Policy into Action by contributing to ACNP's Political Action Committee (PAC). If you would like to help support the efforts of the ACNP-PAC, please email acnp@acnpweb.org for more information.



The American College of Nurse Practitioners (ACNP) dues are not deductible as a charitable contribution for federal income tax purposes, but may be deducted as a business expense. ACNP estimates that 15% of your dues are not deductible because of ACNP's lobbying activities on behalf of its members. ACNP Membership includes a subscription to The Journal for Nurse Practitioners (JNP), ACNP's official peer-reviewed clinical journal.