



NATIONAL ASSOCIATION OF HISPANIC NURSES

Promoting Hispanic Nurses to Improve the Health of Our Communities
Membership Application and Change of Information Form

FORM SUBMISSION IS FOR:

- New Membership
 Membership Renewal (ID Number) _____
 Changes/Updates to your membership
(no payment necessary)

NATIONAL MEMBERSHIP CATEGORIES

Full* For Hispanic/Latino/a nurses licensed in the US and its jurisdictions
Associate Non-Hispanic/Latino/a US-licenses nurses interested in solving problems/needs of Hispanic/Latino/a community
Affiliate For non-nursing health care professionals interested in solving problems/needs of Hispanic/Latino/a nurses
International Licensed Hispanic/Latino/a nurses licensed not residing in the US or its jurisdictions
Retired* For Hispanic/Latino/a US-licensed nurses 62 years or older who are not employed full-time in nursing
Student **PROOF REQUIRED (current transcript + or letter from nursing program) For Hispanic/Latino/a students enrolled in a RN, LPN/LVN program leading to licensure**
**Full (Active) and Retired are the only categories with voting privileges. +Transcript may be obtained from school's website*

Membership Category	National Membership with Chapter Membership	National Membership only (no chapter)
Full	<input type="checkbox"/> \$100	<input type="checkbox"/> \$75
Associate	<input type="checkbox"/> \$75	<input type="checkbox"/> \$50
Affiliate	<input type="checkbox"/> \$75	<input type="checkbox"/> \$50
International	<input type="checkbox"/> \$75	<input type="checkbox"/> \$50
Retired	<input type="checkbox"/> \$65	<input type="checkbox"/> \$40
Student	<input type="checkbox"/> \$40	<input type="checkbox"/> \$30
Corporate	<input type="checkbox"/> N/A	<input type="checkbox"/> \$5,000

Name: *First* _____ *Middle* _____ *Last* _____ Credentials: _____
 Home Address: _____ Apt. _____
 City: _____ State: _____ Zip: _____ Country: _____
 Home Phone: _____ Home Fax: _____ Home E-mail: _____
RN/LPN/LVN License # _____ **Issuing State:** _____ **Expiration Date:** _____
 Employer: _____ Position/Title: _____
 Work Address: _____ Suite: _____
 City: _____ State: _____ Zip: _____ Country: _____
 Work Phone: _____ Work Fax: _____ Work E-Mail: _____

Please sign and return this form along with any other required documentation and your remittance.
 All membership applications must be signed below to comply with postal regulations.

Signature: _____ Date: _____

METHOD OF PAYMENT

- Visa MasterCard American Express
 Check or Money Order made payable to NAHN (Return check fee is \$35)

Card No.: _____ Expiration Date: _____

Cardholder's Name: _____

Signature: _____

AMOUNT ENCLOSED

Membership Dues:
 National With Chapter \$ _____
 National Only \$ _____
 Annual Fund Contribution: (optional) \$ _____
 Scholarship Fund Contribution: (optional) \$ _____
Total Enclosed: \$ _____

LOCAL CHAPTERS*

*National membership is required to join a chapter

LOCAL CHAPTER SELECTION: _____

ARIZONA Yuma (Angeles del Desierto) Tucson Phoenix (Valle del Sol)	San Joaquin Valley COLORADO Denver DELAWARE Delaware DISTRICT OF COLUMBIA Washington DC	ILLINOIS Illinois INDIANA Central Northwest KENTUCKY Kentucky MASSACHUSETTS Massachusetts MICHIGAN Michigan MISSOURI Kansas City (Corazon de la Tierra)	NEVADA Las Vegas NEW JERSEY New Jersey NEW YORK New York NORTH CAROLINA North Carolina OREGON Portland PENNSYLVANIA Philadelphia	PUERTO RICO Puerto Rico RHODE ISLAND Ocean State TEXAS Austin Dallas Houston Lubbock San Antonio WASHINGTON Eastern Washington WISCONSIN Southeastern WI
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MEMBER AMBASSADOR

Referred by: _____ Membership ID: _____
 Please visit the NAHN website for information on the Member Ambassador Program

MEMBER PROFILE

I am a(n): *(select all that apply)*

- RN (year of initial licensure: _____)
- LPN/LVN (year of initial licensure: _____)
- RN Student
(Graduation Year _____ Degree: _____)
- LPN/LVN Student
(Graduation Year _____ Degree: _____)
- Other (specify): _____

Highest Degree Earned:

- Doctorate (Nursing)
(specify): _____
- Doctorate (non-Nursing)
(specify): _____
- Masters (Nursing)
(specify): _____
- Masters (non-Nursing)
(specify): _____
- Baccalaureate
- Associate
- Diploma
- Voc-Tech

Areas of Practice: (select no more than two)

- Administration
- Adolescent
- Adult Health
- Anesthesia
- Child Health
- Community Health
- Education
- Family Health
- Gerontology
- Information Systems
- Managed Care
- Maternal Health
- Mental Health
- Midwifery
- Research
- Women's Health
- Other (specify): _____

Specialty area(s) (select no more than two):

- AIDS/HIV
- Critical Care
- Diabetes
- Emergency Room
- Medical (specify specialty area): _____
- Neonatal
- Oncology
- Surgical (specify specialty area): _____
- Other (specify): _____

National Certification:

- Yes (specify): _____
- No

Employment Status:

- Employed Full-Time in Nursing
- Employed Part-Time in Nursing
- Employed Outside of Nursing
- Retired
- Student
- Unemployed

Work Place: (select no more than two)

- Acute Care Hospital/Multihospital System
- Ambulatory Care/Clinic/HMO
- Association/Foundation
- College/University
- Community College
- Government Agency
- Home Care
- Hospital School
- Military
- Nurse Managed Center
- Nursing Home/Long-Term Care
- Occupational Health
- Private Industry
- Public Health Agency
- Self-Employed
- Voc-Tech
- Other (specify): _____

Type of Position: (select no more than two)

- Clinical Specialist
- Consultant
- Dean/Associate Dean
- Educational/Administrative
- Educator-Clinical
- Faculty-Academic
- Head Nurse
- Human Resource Administration
- Nurse Executive
- Nurse Manager
- Nurse Practitioner
- Private Practitioner
- Researcher
- Sales Representative
- School Nurse
- Staff Nurse/Direct Care Provider
- Student
- Supervisor/Coordinator
- Other (specify): _____

Career Experience:

- Less Than 1 Year
- 1-5 Years
- 6-10 Years
- 11-15 Years
- Over 15 Years

Membership in Other Nursing Organizations

- (select all that apply)
- American Academy of Nursing
 - American Association of Critical-Care Nurses
 - American Nurses Association
 - American Organization of Nurse Executives
 - American Public Health Association
 - Association for Nurses in AIDS Care
 - Association of Operating Room Nurses
 - Association of Women's Health, Obstetrics, and Neonatal Nurses
 - Emergency Nurses Association
 - Oncology Nurses Society
 - Sigma Theta Tau International
 - Other(s) (specify): _____

Are you interested in serving on a NAHN Committee?

- Yes No
- (if yes, please specify)
- Awards/Scholarship
 - Bylaws
 - Development
 - Finance
 - Membership
 - Nominating
 - Policy
 - Public Relations
 - Any

Are you interested in being a NAHN Officer?

- Yes No
- (if yes, please specify):
- President
 - Vice-President
 - Secretary
 - Treasurer
 - Any

DEMOGRAPHIC INFORMATION

1. Age

- Under 21 51-60
- 21-30 61-70
- 31-40 Over 70
- 41-50

2. Gender

- Male Female

3. Marital Status

- Single Married
- Widowed Divorced/Separated

4. Racial/Ethnic Background

- Hispanic/Latino/a African American
- White Asian American
- Native American
- Other (specify): _____

4A. (If Hispanic) Population Subgroup

- Central American
(specify country): _____
- Cuban American
- Dominican
- Mexican American
- Puerto Rican
- South American (specify country): _____
- Spanish (specify): _____
- Other (specify): _____

5. Language(s) Spoken

- Spanish
- English
- Other(s) (specify): _____

6. Annual Personal Income (optional)

- Under \$20,000
- \$20,000 to \$29,999
- \$30,000 to \$39,999
- \$40,000 to \$49,999
- \$50,000 to \$59,999
- \$60,000 to \$69,999
- \$70,000 to \$79,999
- \$80,000 to \$99,999
- \$100,000 to \$125,000
- Over \$125,000
- Do Not Care to Respond

7. Would you like receive information from our sponsors? Yes No