

Membership Application



FOUR EASY WAYS TO JOIN

- **Online:** AAPACN.org/Join
- **Phone:** 800.768.1880 (Monday-Friday, 8 am to 5 pm MT)
- **Fax:** completed application to 303.758.3588
- **Mail:** return completed application with check or credit card payment to:
AAPACN, 400 S. Colorado Blvd. Ste 500, Denver, CO 80246

CONTACT INFORMATION

First Name _____ MI _____ Last Name _____
Home Phone _____ Work Phone _____ Ext. _____ Mobile _____
Home Email _____ Work Email _____
Primary Email (please check one) Home Work
Communications from AAPACN are primarily electronic. Please add @AAPACN.org to your safe-sender list.

WORK ADDRESS

Facility _____
Corporation Name _____
Address 1 _____
Address 2 _____
City, State, Zip _____
Country _____

MAILING ADDRESS (if different than work address)

Address 1 _____
Address 2 _____
City, State, Zip _____
Country _____
Mail to Work Address Yes No

TELL US ABOUT YOURSELF

Gender Male Female Birthday ____/____/____
Job Title _____ Credentials _____ Are You an RN LPN/LVN
First Degree Earned _____ Second Degree Earned _____

Functional Role (please check one)

- | | | |
|-------------------------------|--|---|
| Administrator | LTC Service Provider/Vendor | Reimbursement Specialist/Corporate Consultant |
| ADNS/ADON | Nurse Assessment Coordinator/MDS Coordinator | Social Worker |
| Clinical Consultant | Nurse Consultant | Speech Therapist |
| Corporate Clinical Director | Occupational Therapist | Staff Nurse |
| Dietician | Physical Therapist | Staff Development Educator |
| DNS/DON | Quality Improvement | Other MDS/RAI Professional |
| Health Information Specialist | Professional | Other Nurse Executive |
| Infection Preventionist | Rehabilitation Nurse | Other |

How did you hear about AAPACN? _____ If referred by someone, please include their name _____

MEMBERSHIP DUES

Please remit payment with this application, as applications sent without payment will not be processed.

1-Year AAPACN Membership	\$136
2-Year AAPACN Membership	\$236
I support nursing education and would like to make a charitable donation to the AAPACN Education Foundation*. <small>*The AAPACN Education Foundation supports long-term care nurses with education opportunities.</small>	\$ _____
TOTAL PAYMENT	\$ _____

PAYMENT INFORMATION

CARD TYPE VISA MC AMEX CHECK ENCLOSED
NAME ON CARD _____
CARD NUMBER _____
EXP. DATE _____ CVV _____

Thank you! We look forward to having you as a member of AAPACN. | © 2022 AAPACN