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 600, 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
- ADNS/ADON
- Clinical Consultant
- Corporate Clinical Director
- Dietician
- DNS/DON
- Health Information Specialist
- Infection Preventionist
- LTC Service Provider/Vendor
- Nurse Assessment Coordinator/MDS Coordinator
- Nurse Consultant
- Occupational Therapist
- Physical Therapist
- Quality Improvement
- Professional
- Rehabilitation Nurse
- Reimbursement Specialist/Corporate Consultant
- Social Worker
- Speech Therapist
- Staff Nurse
- Staff Development Educator
- Other MDS/RAI Professional
- Other Nurse Executive
- 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	**$146**
2-Year AAPACN Membership	**$246**
I support nursing education and would like to make a charitable donation to the AAPACN Education Foundation*. **The AAPACN Education Foundation supports long-term care nurses with education opportunities.*	$ ______
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