

# 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  
 Job Title \_\_\_\_\_  
 First Degree Earned \_\_\_\_\_

Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Credentials \_\_\_\_\_ Are You an    RN    LPN/LVN  
 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>	\$ _____
<b>TOTAL PAYMENT</b>	<b>\$ _____</b>

## 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. | © 2021 AAPACN