



STATE NURSES ASSOCIATION MEMBERSHIP APPLICATION

8515 Georgia Avenue • Suite 400 • Silver Spring, MD 20910-3492 • (301) 628-5180 • Fax: (301) 628-5355

DATE _____

Last Name/First Name/Middle Initial _____

Home Phone Number _____

Social Security Number _____

Credentials _____

Work Phone Number _____

Basic School of Nursing _____

Preferred Contact: Home _____ Work _____

Fax Number _____

Graduation (Month/Year) _____

Home Address _____

Date of Birth _____

RN License Number/State _____

Home Address _____

E-mail _____

City/State/Zip _____ County _____

____ UAN member? _____ Not a Member of Collective Bargaining Unit

Employer Name _____

Member of Collective Bargaining Unit other than UAN? (Please specify) _____

Employer Address _____

Employer City/State/Zip Code _____

MEMBERSHIP DUES VARY BY STATE

[Check with your Constituent Member (State) Nurses Association for rates, or call 1-800-923-7709 from 9 am to 5 pm EST Monday to Friday.]

Membership Category (check one)

M Full Membership Dues

- Employed - Full Time
- Employed - Part Time

R Reduced Membership Dues

- Not Employed
- Full Time Student
- New graduate from basic nursing education program, within six months after graduation (first membership year only)
- 62 years of age or over and not earning more than Social Security allows

S Special Membership Dues

- 62 years of age or over and not employed
- Totally Disabled

Please Note:

\$5.42 of the CMA member dues is for subscription to *The American Nurse*. Various amounts are for subscriptions to CMA/DNA newsletters. Please check with your CMA office for exact amount.

State nurses association dues are not deductible as charitable contributions for tax purposes, but may be deductible as a business expense. However, the percentage of dues used for lobbying by the CMA is not deductible as a business expense. Please check with your CMA for the correct amount.

Choice of Payment (please check)

E-Pay (Monthly Electronic Payment)

This is to authorize monthly electronic payments to American Nurses Association, Inc. (ANA). By signing on the line, I authorize my Constituent Member Association (CMA)/ANA to withdraw 1/12 of my annual dues and any additional service fees from my account.

Checking: Please enclose a check for the first month's payment; the account designated by the enclosed check will be drafted on or after the 15th of each month.

Credit Card: Please complete the credit card information below and this credit card will be debited on or after the 1st day of each month.

Automated Annual Credit Card Payment

This is to authorize annual credit card payments to American Nurses Association, Inc. (ANA). By signing on the line, I authorize CMA/ANA to charge the credit card listed in the credit card information section for the annual dues on the 1st day of the month when the annual renewal is due.

Annual Credit Card Payment Authorization Signature
***SEE BELOW**

Payroll Deduction

This payment plan is available only where there is an agreement between your employer and the association to make such deduction.

Monthly Electronic Deduction Authorization Signature
***SEE BELOW**

Full Annual Payment

Membership Investment _____
ANA-PAC (Optional — \$20.04 suggested) _____
Total Dues and Contributions _____

Online: www.NursingWorld.org (Credit Card Only)

Check (payable to ANA) VISA MasterCard

CREDIT CARD INFORMATION

Bank Card Number and Expiration Date _____

Authorization Signature _____

Printed Name _____

Amount: \$ _____

Signature for Payroll Deduction _____

Please mail your completed application with payment to your STATE NURSES ASSOCIATION or to:

**AMERICAN NURSES ASSOCIATION
Customer and Member Billing
P.O. Box 17026
Baltimore, MD 21297-0405**

* By signing the Monthly Electronic Deduction Authorization, or the Automatic Annual Credit Card Payment Authorization, you are authorizing ANA to change the amount by giving the above-signed thirty (30) days advance written notice. Above-signed may cancel this authorization upon receipt by ANA of written notification of termination twenty (20) days prior to deduction date designated above. Membership will continue unless this notification is received. ANA will charge a \$5 fee for any returned drafts or chargebacks.

TO BE COMPLETED BY SNA

Employer Code _____

STATE _____ DIST _____ REG _____

Approved By _____ Date _____

Expiration Date _____ / _____
Month Year

\$ _____
AMOUNT ENCLOSED CHECK # _____

Sponsor, if applicable _____
SNA membership # _____