

ANNA MEMBERSHIP APPLICATION

Name: _____ Credentials: _____
 Home Address: _____
 City: _____
 State/Prov: _____ Zip: _____ Country: _____
 Telephone: _____
 Date of Birth: _____

Employer: _____
 Address: _____
 City: _____
 State/Prov: _____ Zip: _____ Country: _____
 Work Telephone: _____
 Preferred Email*: _____
 Preferred Daytime Telephone: Home Work
 Preferred Address: Home Work
 Who asked you to join ANNA? _____

* Email addresses are required to access the ANNA website and receive ANNA E-News.
 Please note that ANNA does not release e-mail addresses to any outside vendors.

SAVE TIME
 Join ANNA online at www.annanurse.org/join

A. PROFESSIONAL STATUS: <i>Full Member</i> <input type="checkbox"/> RN <input type="checkbox"/> APRN <i>Associate Member</i> <input type="checkbox"/> LPN/LVN <input type="checkbox"/> Technician <input type="checkbox"/> Social Worker <input type="checkbox"/> Dietitian <input type="checkbox"/> Physician <input type="checkbox"/> Industry <input type="checkbox"/> Other _____	B. POSITION: <input type="checkbox"/> Head Nurse/ Supervisor <input type="checkbox"/> Staff/Clinical Nurse <input type="checkbox"/> Education <input type="checkbox"/> Administration <input type="checkbox"/> Clinical Nurse Specialist <input type="checkbox"/> Coordinator <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Case Manager <input type="checkbox"/> Retired <input type="checkbox"/> Other _____	C. YEARS IN NEPHROLOGY NURSING: <input type="checkbox"/> One <input type="checkbox"/> Two <input type="checkbox"/> Three <input type="checkbox"/> Four <input type="checkbox"/> Five-nine <input type="checkbox"/> Ten-fourteen <input type="checkbox"/> Fifteen-nineteen <input type="checkbox"/> Twenty or more	D. YEARS IN CURRENT POSITION: <input type="checkbox"/> One <input type="checkbox"/> Two <input type="checkbox"/> Three <input type="checkbox"/> Four <input type="checkbox"/> Five-nine <input type="checkbox"/> Ten-fourteen <input type="checkbox"/> Fifteen-nineteen <input type="checkbox"/> Twenty or more	E. HIGHEST NURSING DEGREE: (RNs only) <input type="checkbox"/> Diploma-Nursing <input type="checkbox"/> Associate Degree-Nursing <input type="checkbox"/> Bachelor's Degree-Nursing <input type="checkbox"/> Master's-Nursing <input type="checkbox"/> Doctorate-Nursing F. HIGHEST LEVEL OF EDUCATION COMPLETED: (If different than E) <input type="checkbox"/> Associate Degree-Other <input type="checkbox"/> Bachelor's Degree-Other <input type="checkbox"/> Master's-Other <input type="checkbox"/> Doctorate-Other <input type="checkbox"/> Other _____
ANNA occasionally makes available its members' mailing addresses (not telephone or email) to organizations/vendors who provide products and services to the nephrology nursing community. If you do not wish to receive mailings, you may opt out by calling the National Office at 888-600-2662.				
G. PRIMARY PRACTICE SETTING/EMPLOYER: <input type="checkbox"/> Community/University Hospital Medical Center-Inpatient <input type="checkbox"/> Community/University Hospital Medical Center-Outpatient <input type="checkbox"/> Freestanding Dialysis Unit <input type="checkbox"/> Other Inpatient/Outpatient/Extended Care/Prisons/Private Settings <input type="checkbox"/> Corporate/Government/College/University <input type="checkbox"/> Self-Employed <input type="checkbox"/> Not Employed	H. AREAS OF PRACTICE: (check all that apply) <input type="checkbox"/> Acute Care <input type="checkbox"/> Chronic Hemodialysis <input type="checkbox"/> Chronic Kidney Disease <input type="checkbox"/> Conservative Management <input type="checkbox"/> Continuous Renal Replacement Therapy <input type="checkbox"/> Medical-Surgical Unit <input type="checkbox"/> Nursing Education <input type="checkbox"/> Pediatric Nephrology <input type="checkbox"/> Peritoneal Dialysis <input type="checkbox"/> Research <input type="checkbox"/> Therapeutic Apheresis <input type="checkbox"/> Transplantation <input type="checkbox"/> Other _____	I. ARE YOU A MEMBER OF YOUR STATE NURSING ASSOCIATION (i.e. ANA)? <input type="checkbox"/> YES <input type="checkbox"/> NO J. CERTIFICATION STATUS: (mark all that apply) <input type="checkbox"/> CNN <input type="checkbox"/> CDN <input type="checkbox"/> CCRN <input type="checkbox"/> CDE <input type="checkbox"/> Certified by ANA <input type="checkbox"/> CNN-NP <input type="checkbox"/> CCHT <input type="checkbox"/> Other _____	K. SPECIALTY PRACTICE NETWORKS (SPNs): <input type="checkbox"/> Acute Care <input type="checkbox"/> Administration <input type="checkbox"/> Advanced Practice <input type="checkbox"/> Chronic Kidney Disease <input type="checkbox"/> Educator <input type="checkbox"/> Health Policy <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Home Therapies <input type="checkbox"/> Pediatric Nephrology <input type="checkbox"/> Transplantation <input type="checkbox"/> I do not wish to participate in the ANNA Connected Open Forum	L. GENDER: <input type="checkbox"/> Male <input type="checkbox"/> Female M. ETHNICITY: <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> African American/Black <input type="checkbox"/> Filipino <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other _____ N. OPTIONAL GO GREEN All members receive printed publications in the mail. Check below only if you DO NOT want to receive printed publications in the mail: <input type="checkbox"/> Nephrology Nursing Journal <input type="checkbox"/> ANNA Update

Member Rates	
Yearly Dues:	
<input type="checkbox"/> Full Member	\$80
<input type="checkbox"/> Associate Member	\$70
<input type="checkbox"/> International Member	\$120
<input type="checkbox"/> Student in RN Program*/Senior Member**	\$40
<input type="checkbox"/> Virtual International Member	\$70
2 Year:	
<input type="checkbox"/> Full Member***	\$130
<input type="checkbox"/> Associate Member***	\$120
<input type="checkbox"/> International Member	\$220
<input type="checkbox"/> Virtual International Member***	\$120
3 Year:	
<input type="checkbox"/> Full Member	\$200
<input type="checkbox"/> Associate Member	\$180
<input type="checkbox"/> International Member	\$320
<input type="checkbox"/> Virtual International Member	\$180

*Please submit proof of enrollment in a nursing program leading to initial licensure as an RN.
 **Age 65+ and have been a member for the previous 5 consecutive years.
 ***ANNA 50 Years – \$50 dues for year two. (When you join/renew for two years.)

My check is enclosed for \$ _____
 (Make check payable to ANNA in U.S. Funds). \$38.00 of the membership dues is applied to subscriptions to the Nephrology Nursing Journal and ANNA Update. International and Virtual International membership is applicable for members residing outside North America.
 Charge my credit card in the amount of \$ _____ VISA Mastercard American Express
 Account number: _____ Card Security Code*: _____
 (*3-Digit code found on **back** of Visa and Mastercard; 4-Digit code on **front** of American Express.)
 Expiration date: _____ Signature: _____
 Print cardholder's name: _____
 Billing address of cardholder if different than above: _____



Special 50th Anniversary offer valid 9/1/18-12/31/19.

Send completed application with payment to:
ANNA
East Holly Avenue, Box 56
Pitman, NJ 08071-0056
 or fax to 856-218-0557 or join online at
www.annanurse.org/join

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