



Asian American Pacific Islander Nurses Association, Inc.

Member No. _____

Regular Member \$60 Renewal New (referred by _____)
 Associate Member (not RN) \$40 Renewal New (referred by _____)
 Organizational Membership \$500 Name: _____

Last Name	First Name	Middle Initial	Position/Title
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Check Highest Degree Earned:

LVN/LPN RN BSN MS/MSN/MN PhD Other _____

Office Address (Preferred Mailing Address):

Address: _____

Phone: _____ Fax: _____ E-mail: _____

Home Address (Preferred Mailing Address):

Address: _____

Phone: _____ Fax: _____ E-mail: _____

Work Setting:

Clinic Federal/State/Local Health Hospital Industry
 Military University Other _____

Clinical Practice:

Adult Medical Adult Surgical Cardiovascular Critical Care Family
 Geriatrics Labor/Delivery Occupational Health Psychiatric/Mental Health Pediatrics
 Public Health Pulmonary Rehabilitation Other _____

Please Let Us Know:

1. How can AAPINA be of service to you? _____

2. Would you like to be actively involved with AAPINA activities?

AAPINA Office Membership Planning Other _____

3. Have you recruited any prospective members this year? No Yes (Please list their names below)

Name: _____ Name: _____ Name: _____

4. If new member, how did you learn about AAPINA?

AAPINA member _____ AAPINA flyer Other _____

5. Would you like to be included in the membership directory? No Yes

6. Other Comments? _____

Membership Cycle: Jan-Dec. Please make check payable to AAPINA and mail to: Patricia Alpert, Treasurer, AAPINA, c/o School of Nursing, University of Nevada, Las Vegas, 4505 Maryland Parkway, Box 453018, Las Vegas, NV 89154-3018.