Completed applications should be mailed with payment to:

MEMBERSHIP APPLICATION | www.phnurse.org | APHN | 110A Northwoods Blvd | Columbus, OH 43235

CONTACT INFORMATION

FIRST NAME LAST NAME CREDENTIALS

TITLE LICENSE # STATE ISSUED

ORGAJNIZATION/AGENCY AFFILIATION

ADDRESS

CITY STATE ZIP CODE

BUSINESS PHONE

E-MAIL ADDRES

MEMBERSHIP TYPE

☐ $400.00 – **Official State or Territorial Representative/Designee**
A registered nurse who serves as the State/Territorial Nursing Director or is designated as the official representative by the State/Territorial Health Official of that jurisdiction

☐ $120.00 – **Public Health Nurse**
A registered nurse working in the field of public health including, but not limited to, those working in a local, state, or federal governmental public health agency or department, school health, higher education and community based nursing, but who is not the Official State or Territory Representative

☐ $50.00 – **Retired Public Health Nurse**
A retired, registered nurse who formerly served as a public health nurse in any capacity in the field of public health

☐ $50.00 – **Friend of APHN**
A non-nurse individual with an interest in public health nursing

☐ $25.00 – **Student**
Person enrolled full- or part-time (minimum of 6 credit hours) who is actively pursuing a degree. Proof of status is required.

☐ **Donate**
I would like to donate _____ to the mission and purposes of APHN.

TOTAL: $ ____

☐ "I certify that I meet all the membership qualifications required for the membership type that I have selected above. If I checked one of the first 3 membership types set forth above, I certify that I am a registered nurse in good standing without encumbrance or disciplinary action. For all membership types, I support the mission and purposes of APHN."