Student Membership Application

AAPACN
AMERICAN ASSOCIATION OF POST-ACUTE CARE NURSING

FOUR EASY WAYS TO JOIN

- Complete the form below
- Attach proof of full-time student status
- **Email:** send completed application to memberexperience@aapacn.org
- **Mail:** return completed application with check or credit card payment to:
  AMERICAN ASSOCIATION OF POST-ACUTE CARE NURSING, PO Box 202254, Dallas, TX 75320-2254

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

Birthday _____/_____/_____

Job Title _____

Credentials _____ Are You an ◯ RN ◯ LPN/LVN

First Degree Earned _____

Second Degree Earned _____

Functional Role *(please check one)*

- ◯ Administrator
- ◯ ADNS/ADON
- ◯ Clinical Consultant
- ◯ Corporate Clinical Director
- ◯ Dietitian
- ◯ DNS/DON
- ◯ Health Information Specialist
- ◯ Infection Preventionist
- ◯ LTC Service Provider/Vendor
- ◯ Nurse Assessment Coordinator/MDS Coordinator
- ◯ Nurse Consultant
- ◯ Occupational Therapist
- ◯ Physical Therapist
- ◯ Quality Improvement
- ◯ Professional
- ◯ Rehabilitation Nurse
- ◯ Reimbursement Specialist/Corporate Consultant
- ◯ Social Worker
- ◯ Speech Therapist
- ◯ Staff Nurse
- ◯ Staff Development Educator
- ◯ Other MDS/RAI Professional
- ◯ Other Nurse Executive
- ◯ 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 Student Membership	**$54**
I support nursing education and would like to make a charitable donation to the AAPACN Education Foundation*. **The AAPACN Education Foundation supports long-term care nurses with education opportunities.*	$ _____
TOTAL PAYMENT	$ _____

PAYMENT INFORMATION

Student memberships are non-transferable and non-refundable. Annual proof of full-time student status is required to receive student member pricing.

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.* |