Membership Application

AAPACN
AMERICAN ASSOCIATION OF POST-ACUTE CARE NURSING

FOUR EASY WAYS TO JOIN

- **Online: AAPACN.org/Join**
- **Phone: 800.768.1880** *(Monday-Friday, 8 am to 5 pm MT)*
- **Fax:** completed application to **303.758.3588**
- **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

(if your company does not have facilities, add your company's name to both the "Facility Name" and "Corporation Name" fields)

Facility Name _____

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)*

- ◯ ADON/ADNS
- ◯ Clinical Nurse Consultant (regional, corporate)
- ◯ Corporate executive (VP or higher)
- ◯ Dietitian/Dietary Manager
- ◯ DON/DNS
- ◯ Executive Director/Administrator
- ◯ Health Information Specialist
- ◯ Infection Preventionist
- ◯ LTC Service Provider/Vendor
- ◯ Nurse Assessment Coordinator/MDS Coordinator
- ◯ Quality Improvement Professional
- ◯ Reimbursement Consultant (regional, corporate)
- ◯ Restorative/Rehabilitation Nurse
- ◯ Social Worker
- ◯ Staff Nurse
- ◯ Therapist (occupation, physical, speech)
- ◯ Other

How did you hear about AAPACN? _____

If referred by someone, please include their name _____

ORGANIZATION CATEGORY

- ◯ Government/Government Contractor
- ◯ Home Health Agency
- ◯ Hospice
- ◯ Inpatient Rehabilitation Facility
- ◯ Long-Term Care Hospital
- ◯ Professional Services (training, consulting)
- ◯ Skilled Nursing Facility
- ◯ Therapy Company
- ◯ Vendor/Supplier
- ◯ Other

MEMBERSHIP DUES

Please remit payment with this application, as applications sent without payment will not be processed.

1-Year AAPACN Membership	**$168**
2-Year AAPACN Membership	**$305**
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

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.* |