

1-800-262-6877 | www.aaacn.org | aaacn@ajj.com

AAACN Group Membership Application

Your membership dues will be paid by your employer through AAACN's Group Membership Program.

Name: _____ Credentials: _____

☐ Preferred Mailing Address (check one)

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: () _____

Employer: _____

Work Address: _____

City: _____ State: _____ Zip: _____

Business Phone: () _____ Fax #: () _____

Preferred Daytime Phone: ☐ Home ☐ Work

E-mail: * _____

- ☐ Registered Nurse
- ☐ LPN/LVN

*AAACN **does not** sell or share member e-mail addresses with any outside parties. It is extremely important for us to have your e-mail address to send your dues renewal notice, monthly E-newsletters, and other timely information.

Fax this form to (856) 218-0557 or mail to: AAACN, PO Box 56, Pitman, NJ 08071-0056
(800) 262-6877 | aaacn@ajj.com | www.aaacn.org

Please circle one answer for each question.

1. Position

Administrator/Director
Advanced Practice
Care Coordinator
Consultant
Educator
Manager/Supervisor
Researcher
Staff Nurse
Other _____

2. Practice Setting

College/Educational Institution
Community Hospital
Free Standing Facility
Hospital-based Outpatient
Clinic/Center
Managed Care/HMO/PRO
Military or VA
Patient Homes
Solo/Group medical practice
Telehealth Call Center
University Hospital
Other _____

3. Highest Level of Education Completed

LPN/LVN
Diploma—Nursing
Associate Degree—Nursing
Associate Degree—Other
Bachelor's Degree—Nursing
Bachelor's Degree—Other
Master's Degree—Nursing
Master's Degree—Other
Doctorate Degree, Nursing
Doctorate Degree, Other

4. If you are involved in clinical care, please circle the area that best describes your practice.

Ambulatory Surgery
Behavioral Health
Family Practice
General Surgery
Internal Medicine
Medical Specialties
Multispecialty Clinic
Obstetrics/Gynecology
Oncology
Orthopaedics/Rehabilitation
Pediatrics
Primary Care
Surgical Specialties
Telehealth
Other _____

5. If you are in an administrative/managerial position, please circle ONE area that best describes your area of responsibility.

Ambulatory Surgery
Community/Public Health
Employee/Occupational Health
Hospital-based Emergency Services
Information Management
Nurse-Managed Center
Oncology Clinic
Patient Education
Physician Group Office
Practice/Primary Care
Rehabilitation Outpatient
Specialty/Sub-specialty Physician
Practice
Staff Education
Triage
Urgent/Immediate Care Center

6. Are you Certified? (Circle all that apply)

Ambulatory Nursing ANCC
Care Coordination MSNCB
Telehealth NCC

7. Choose membership in as many Special Interest Groups (SIG) as you would like).

Leadership
Patient/Staff Education
Pediatrics
Telehealth Nursing Practice
Tri-Service Military
Veterans Affairs

8. Salary (Confidential)

\$24,999 or less
\$25,000 - \$44,999
\$45,000 - \$64,999
\$65,000 - \$84,999
\$85,000 - \$105,000
more than \$105,000

9. Select the journal you would like to receive as part of your membership benefits.

MEDSURG Nursing
Nursing Economic\$
Pediatric Nursing

10. How did you hear about AAACN?

A member
AAACN Conference
AAACN Enews
Another Conference
Certification organization
Colleague
ViewPoint Newsletter
Web site

11. Select how you will receive your ViewPoint newsletter

By E-mail
By Mail

12. What is your birthday month:

13. What is your birthday year:

Who referred you to AAACN?