



American Nurses Association \ California Membership Application



Last Name/First Name/Middle Initial

Credentials

Date of Application

/ /

Mailing Address

Apt. / Unit Number

Home Phone Number

()

City / State

Postal Code 'Zip'

Home Fax Number

()

Basic School of Nursing

Year Graduated

License Number / State

Employer Name

Email Address

Title/Building/Department

Business Phone

Business Fax

()

()

Address

Preferred Contact Method

Home Work

Employer City / State

Postal Code 'Zip'

Referred By:

MEMBERSHIP DUES VARY BY STATE

Membership Category (Check one)

M Full Membership Dues - \$267.00

- Employed – Full Time
- Employed – Part Time

R Reduced Membership Dues – \$133.50

- Not Employed
- Full Time Student
- New graduate from basic nursing education program, within six months after graduation (first membership year only)
Grad. Date _____
- 62 years of age or over and not earning more than Social Security allows

S Special Membership Dues - \$66.75

- 62 years of age or over and not employed
- Totally Disabled

Payment Plan (Check One)

Full Annual Payment

- Check
- Master Card or VISA Bank Card
(Available for Annual payment only)

Payment Plan (continued)

Electronic Dues Payment Plan (EDPP)

Read and sign the authorization below, enclose a check for first month's EDPP payment (contact your SNA/DNA for appropriate rate and fee). 1/12 of your annual dues will be withdrawn from your checking account each month in addition to a monthly service fee.

Bank Card Number and Expiration Date

Signature of Card Holder

AUTHORIZATION to provide monthly electronic payments to American Nurses Association (ANA)

This is to authorize ANA to withdraw 1/12 of my annual dues and any additional service fees from my checking account designated by the enclosed check for the first month's payment. ANA is authorized to change the amount withdrawn by giving the undersigned thirty (30) days written notice. The undersigned may cancel this authorization upon receipt by ANA, written notification of termination twenty (20) days prior to the deduction date as designated above.

ANA will charge a \$5.00 fee for any return drafts.

Signature for EDPP Authorization

Note:
\$7.50 of the SNA member dues is for subscription to *The American Nurse*. A percentage of your dues may or may not be applied to an SNA/DNA subscription.

State nurses association dues are not deductible as charitable contributions for tax purposes, but may be deductible as a business expense. However, that percentage of dues used for lobbying by the SNA is not deductible as a business expense. Please check with your SNA for the correct amount.

Mail with payment to:

Customer and Member Billing
c/o American Nurses Association
PO Box 504345
St. Louis MO 63150-4345

TO BE COMPLETED BY SNA

Employer Code _____

STATE _____ DIST _____ REG _____

Approved by _____ Date _____

Expiration Date _____ / _____

\$ _____

Sponsor, if applicable

SNA membership # _____

Month Year

AMOUNT ENCLOSED

CHECK #