



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	Business Phone	
Title/Building/Department	Business Fax	
Address	Postal Code	
Employer City / State	E-mail Address	

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

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.

Payment Plan (Check One)

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

Bank Card Number and Expiration Date

Signature of Card Holder

Payment Plan (continued)

- Electronic Dues Payment Plan (EDPP)**

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a check for first month's EDPP payment (contact your SNA/DNA for appropriate rate). 1/12 of your annual dues will be withdrawn from your checking account each month in addition to a monthly service fee.

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 by giving the undersigned thirty (30) days written notice. The undersigned may cancel this authorization upon receipt by ANA of 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

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

STATE _____	DIST _____	REG _____	Employer Code _____	Approved by _____	Date _____
Expiration Date _____ / _____			\$ _____		Sponsor, if applicable _____
Month	Year	AMOUNT ENCLOSED	CHECK # _____		
			SNA membership # _____		