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WWW.RISNARN.ORG
membership@risnarn.org

RISNA MEMBERSHIP ONLY

Date: _____

 Last Name/First Name/Middle Initial

 Credentials License # State

 Home Address

 Home Phone Number Home Fax Number

 City/State Zip Code

 Home Email Address

 Employer

 Alternate Email Address

 Title/Practice Setting/Specialty

 Work Phone

RISNA Membership Benefits

- ◆ Discounted rate on **ALL** RISNA Continuing Education Programs
- ◆ RISNA newsletter
- ◆ Direct mailings and/ or emails on RISNA events/programs/activities
- ◆ First hand and accurate information on laws/rules and information pertinent to your profession

Dues for RISNA member only \$155.00 annually (make check payable to RI State Nurses Assoc)

Enclosed is also a donation for ___\$5.00 ___\$10.00 \$_____ to the RISNA-PAC to secure Nursings/RISNA's active participation in RI's political arena. *****PLEASE NOTE ALL DONATIONS TO RISNA/PAC MUST BE ON A SEPARATE CHECK*****

**American Express/Discover
 Mastercard/Visa**

 Card Number Expiration Date
 3 Digit Code (from back of card – required) _____ Signature _____

Do you want to be on the (please check) _____ NP list serve? _____ PCNS list serve?

❖ Are you interested in serving on a committee? _____yes _____no

❖ Would you like to have a member of the nominating committee contact you to determine your area of interest of running for an elective seat on a committee? _____yes _____no
 as an elected leader? _____yes _____no

Preferred way of contact:

email _____ OR phone number _____ (complete if different from above)

(This membership option entitles you to all the benefits of RI State Nurses Association only. It does not; however, entitle you to the benefits of ANA)