

PNASC MEMBERSHIP APPLICATION

NEW _____ **RENEWAL** _____

Date _____ Check # _____

Name _____

Professional Credentials _____

Address _____

City _____

State _____ Zip + 4 _____

Phone (H) _____

(W) _____

(E-Mail) _____

Social Security # (Optional) _____

Birth Date (Optional) _____

NYS RN License # _____

Employer _____

Position Title _____

Nursing Students (Associates)

Nursing School _____

Expected Date of Graduation _____

Annual Fee: RN's.....\$ 40

Student Associates.....\$ 18

Please make check payable to **PNASC**

mail to: **PNASC, P.O. Box 885**

Patchogue, NY 11772

(Membership Year is January to December)

PNASC SCHOLARSHIP FUND

If you would like to make a contribution to the scholarship fund you can include it with your dues. Please fill in the amount you wish to add.

Thanks!! \$ _____