

PNASC MEMBERSHIP APPLICATION

NEW _____

RENEWAL _____

Please print all information

Date _____

Check # _____

Name _____

Professional Credentials _____

Birth Date _____

Address _____

City _____

State _____ Zip + 4 _____

Phone (H) _____ (W) _____

(Cell Phone) _____

E-Mail _____

NYSNA Member From _____ To _____

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!! \$ _____