



CAPITAL DISTRICT NURSES ASSOCIATION

No. 9 - New York State Nurses Association

P.O. Box 16066

Albany, New York 12212

Capital District Nurses Association Membership Application

New Member

Renewing Member

(Please Print)

Name: _____

Address: _____

City: _____

State/Zip: _____

Telephone: (Home) _____ (Work) _____ (Cell) _____

Preferred E-mail: _____

Current Employment, Role and Employer _____

Employment Information

Position/Title: _____

Employer: _____

Area of Specialization: _____

Educational areas of interest: _____

I was referred to District #9 & NYSNA by: _____

Would you like to make an additional donation to the District #9 Scholarship Fund, which is used to assist in funding the education of area nurses? Yes No

Annual Membership Dues - \$45.00 /yr	\$
Graduate rate – \$10 first year Month/year of graduation _____	\$
*Retiree rate- Month/year of Retirement _____	\$
Scholarship Fund Donation	\$
Amount Enclosed:	\$

**Retirees may qualify for a reduced membership rate if they are 62 years or older and not working. Please contact us for details.*

Membership dues apply to Capital District Nurses Association, No. 9. For membership in the New York State Nurses Association visit: <http://www.nysna.org/general/membership/main.htm>

Please mail application form and check to:

Capital District Nurses Association, No. 9
No. 9, NYSNA
P.O. Box 16066
Albany, NY 12212

QUESTIONS? Email us at:

capital.district.nurses.9@gmail.com

Please make checks payable to: Capital District Nurses Association