

## Group Participant Information: NYSNA 2010 Lobby Day

NURSE:	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NURSING STUDENT	NYSNA MEMBER:	<input type="checkbox"/> YES <input type="checkbox"/> NO
NAME:		CREDENTIALS:	
ADDRESS:		APT #:	
CITY:		STATE, ZIP (+4):	
PHONE #		EMAIL:	

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