

# KENTUCKY NURSES ASSOCIATION

## Membership Application Form

I heard about KNA from (please check):

- |   |                                       |  |
|---|---------------------------------------|--|
| <input type="checkbox"/> KNA Member _____<br>(Name) | <input type="checkbox"/> Presentation | <input type="checkbox"/> KANS              |
| <input type="checkbox"/> Mailing/Publication        | <input type="checkbox"/> Exhibit      | <input type="checkbox"/> School of Nursing |
|   |                                       | <input type="checkbox"/> Other _____       |

Ms. \_\_\_\_\_  
Mr. \_\_\_\_\_

Last Name	First Name	Initial
Mailing Address _____		
City	State	Zip
R. N. License #		State

Credentials (RN, BSN, C., etc.) \_\_\_\_\_

Graduation: MO/YR _____	From Prelicensure Program _____
Home Phone _____	Work Phone _____
Employer Name _____	Job Title _____
Employer City/State/Zip _____	
Fax Number _____	Email Address _____

### I. MEMBERSHIP CATEGORIES (choose one)

- \_\_\_ FULL MEMBER
- \_\_\_ ASSOCIATE MEMBER (receives full benefits) (select one)
- \_\_\_ 1) RN enrolled in at least half time study as defined in KNA policies\*  
(KNA reserves the right to verify enrollment)
- \* School \_\_\_\_\_
- \_\_\_ 2) Graduate of prelicensure program within one year of graduation
- \_\_\_ 3) Registered nurse not employed
- \_\_\_ SPECIAL MEMBER (select one)
- \_\_\_ 1) Registered nurse who is retired and not actively employed in nursing
- \_\_\_ 2) Registered nurse who is currently unemployed as nurse due to disability
- \_\_\_ 3) Impaired registered nurse with limited membership

**Make Checks Payable to:**  
**AMERICAN NURSES ASSOCIATION**

### MAIL CHECK AND APPLICATION TO:

KENTUCKY NURSES ASSOCIATION  
P. O. Box 2616  
Louisville, KY 40201  
Tel: (502) 637-2546 or 800-348-5411 Fax: (502) 637-8236

NOTE: Your dues include \$18.00 subscription fee for the **Kentucky Nurse**, \$7.50 for **The American Nurse**, and \$14.00 for the **American Journal of Nursing**.

State nurses association dues are not deductible as charitable contributions for tax purposes, but may be deductible as a business expense. Consult your tax advisor.

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### II. PAYMENT OPTIONS

(Amount Includes ANA/KNA/District Membership)

- FULL MEMBER**
- \_\_\_ Monthly - \$23.92 - Withdrawal from your checking account.  
(Enclose check for 1st month payment. Signature is required below.\*  
See **monthly bank draft** section)
- \_\_\_ Annual - \$287.00 - Enclose check or pay by credit card

#### BANK CARD INFORMATION

_____ Visa/Mastercard	_____ Card expiration date
_____ Signature	

#### ASSOCIATE MEMBER

- \_\_\_ Monthly - \$11.96 - Withdrawal from your checking account  
(Enclose check for 1st month payment. Signature is required below.\*  
See **monthly bank draft** section.)
- \_\_\_ Annual - \$143.50 - Enclose check

#### SPECIAL MEMBER

- \_\_\_ Monthly - \$5.98 - Withdrawal from your checking account  
(Enclose check for 1st month payment. Signature is required below.\*  
See **monthly bank draft** section)
- \_\_\_ Annual - \$71.75 - Enclose check

#### \*MONTHLY BANK DRAFT

In order to provide for convenient monthly payments to American Nurses Association, Inc (ANA), this is to authorize ANA to withdraw 1/12 of my annual dues from my checking account on the 15th of each month; ANA is authorized to change the amount by giving the undersigned thirty (30) days written notice; the undersigned may cancel this authorization upon written receipt by the 15th of each month

\* \_\_\_\_\_  
Signature for Bank Draft Authorization

#### Areas of Interest

- |  |   |
|--|---|
| <input type="checkbox"/> Amb/Community Health          | <input type="checkbox"/> Psych. & Mental Health       |
| <input type="checkbox"/> Adult/Gerontological          | <input type="checkbox"/> Advanced Practice Nursing    |
| <input type="checkbox"/> Women's & Children's Health   | <input type="checkbox"/> Critical Care/Emergency      |
| <input type="checkbox"/> Staff Nurse                   | <input type="checkbox"/> Ways & Means Committee       |
| <input type="checkbox"/> Finance Committee             | <input type="checkbox"/> Historical Committee         |
| <input type="checkbox"/> Convention Program Planning   | <input type="checkbox"/> Membership Recruitment Com   |
| <input type="checkbox"/> Policy Committee              | <input type="checkbox"/> Strategic Planning Committee |
| <input type="checkbox"/> Other areas of interest _____ |   |

I am an actively licensed RN (check one):  
In a Non-Supervisory, Non-Management role \_\_\_\_\_  
In a Supervisory, Management role \_\_\_\_\_

**Legislative Information:** House District # \_\_\_\_\_ Senate District # \_\_\_\_\_

Are you a registered voter?  YES  NO Party \_\_\_\_\_

**Professional Liability Insurance:** Please send an application \_\_\_\_\_

#### PLEASE COMPLETE INFO ON BACK

KNA Use Only	
State _____	District _____
Exp. Date _____	Payment Code _____
Approved by _____	Date _____
Amount Enclosed _____	

The following information is not reported except in the aggregate when necessary. (Select One from each category)

**State Nurses Association Groups**

- 1. Educational Administrators, Consultants and teachers
- 2. Staff Nurses
- 3. Private Duty
- 4. Nursing Service Administration
- 5. Occupational Health
- 6. Office Nurse
- 7. Public Health
- 8. Psychiatric and Mental Health
- 9. School Nurse
- A. Head Nurse
- B. Operating Room
- C. Other (specify) \_\_\_\_\_

**Employment Status**

- 1. Full time in nursing
- 2. Part time in nursing
- 3. Full time not nursing
- 4. Part time not nursing
- 0. Looking for work in nursing
- 5. Looking for other work

- 6. Not looking for work
- 7. Retired
- 8. Student
- 9. Other (specify) \_\_\_\_\_

**Field/Place of Employment**

- 0. Private Practice
- 1. Hospital
- 2. Nursing Home
- 3. School of Nursing
- 4. HMO/Free Standing Clinics
- 5. Community / Home / Public Health
- 6. School Nurse
- 7. Occupational Health Nurse
- 8. Office Nurse (Physician / Dentist)
- 9. Other (specify) \_\_\_\_\_

**Type of Position**

- 0. Researcher
- 1. Administrator
- 2. Consultant
- 3. Supervisor (Manager)

- 4. Educator
- 5. Head Nurse (Manager)
- 6. Staff Nurse
- 8. Nurse Practitioner
- 9. Clinical Specialist (Master's Degree or above)
- 7. Other (specify) \_\_\_\_\_

**Highest Level of Education Completed**

- 1. Diploma
- 2. Associate Degree
- 3. Baccalaureate in Nursing
- 4. Baccalaureate in other field
- 5. Master's in Nursing
- 6. Master's in other field
- 7. Doctorate in Nursing
- 8. Doctorate in other field

**Major Clinical Teaching or Practice Area**

- 1. Community/Public Health
- 2. General Practice
- 3. Gerontology
- 4. OB/GYN/Neonatal
- 5. Medical/Surgical
- 6. Pediatrics
- 7. Psychiatric/Mental Health
- 8. Other (specify) \_\_\_\_\_

**Race / Ethnic Group**

- 1. White
- 2. Black
- 3. Hispanic
- 4. American Indian or Alaskan Native
- 5. Asian or Pacific Islander
- 0. Other (specify) \_\_\_\_\_

**Sex**

- 1. Male
- 2. Female

**Year of Birth** \_\_\_\_\_

fold here \_\_\_\_\_

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Kentucky Nurses Association  
P. O. Box 2616  
Louisville, KY 40201-2616

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