

# AACN Application for Membership

## Step 1 – Demographic Information

New Member    Renewing Member: AACN Member Number \_\_\_\_\_  
 Last Name \_\_\_\_\_ First Name \_\_\_\_\_ (MI) \_\_\_\_\_  Male  Female  
 Home Mailing Address \_\_\_\_\_ Apt/Unit # \_\_\_\_\_  
 City/State/ZIP \_\_\_\_\_ Preferred Mailing Address:  Home  Work/School  
 Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ Fax \_\_\_\_\_  
 E-mail Address \_\_\_\_\_  
 Credentials \_\_\_\_\_ RN License # \_\_\_\_\_ State \_\_\_\_\_ Exp \_\_\_\_\_  
 Employer Name \_\_\_\_\_  
 Employer Address \_\_\_\_\_  
 City/State/ZIP \_\_\_\_\_

## Step 2 – Membership Types and Dues\*

	One-Year	Two-Year	Three-Year	Total Due
<b>Active Membership</b> (Active U.S. RN License)	<input type="checkbox"/> \$78.00	<input type="checkbox"/> \$148.00	<input type="checkbox"/> \$211.00	\$ _____
<b>Affiliate Membership</b> (Non-RN Healthcare Professional)	<input type="checkbox"/> \$78.00	<input type="checkbox"/> \$148.00	<input type="checkbox"/> \$211.00	\$ _____
<b>International Membership</b> (Active Non-U.S. RN License)	<input type="checkbox"/> \$104.00	<input type="checkbox"/> \$196.00	<input type="checkbox"/> \$280.00	\$ _____
<b>Student Membership</b> (Non-RN Licensed Student)	<input type="checkbox"/> \$52.00	—	—	\$ _____
<b>Emeritus Membership</b> (Aged 55+ and an active AACN member for 5 years)	<input type="checkbox"/> \$52.00	<input type="checkbox"/> \$99.00	<input type="checkbox"/> \$141.00	\$ _____
<b>Retired/Disabled Membership</b> (Ceased active practice due to permanent retirement or disability)	<input type="checkbox"/> \$52.00	—	—	\$ _____
<b>AACN Certification Membership</b> Certification Number: _____ (Any active CCRN®, CCNS®, PCCN™, CMC™ or CSC™ certified nurse)			<input type="checkbox"/> \$179.35	\$ _____

\*Annual membership dues include a non-refundable payment for a one-year subscription to *Critical Care Nurse*® (\$12.00) and the *American Journal of Critical Care*® (\$15.00)

## Step 3 – Payment Information

Enclosed is my check for the full amount, made payable to AACN (U.S. funds drawn on a U.S. bank)  
 Please bill my credit card for the full amount (fill out information below)  
 Name (as it appears on the card) \_\_\_\_\_  
 Visa    MasterCard    American Express    Discover  
 Credit Card # \_\_\_\_\_ Exp. Date \_\_\_\_\_  
 Billing Address (if different from above) \_\_\_\_\_  
 City/State/ZIP \_\_\_\_\_  
 Signature \_\_\_\_\_  
 Referral By: (Name:) \_\_\_\_\_  Chapter  
**For Member-Get- A- Member program referral incentives specify one**    Individual Name

## Step 4 – Join AACN Today!

**Mail or fax this completed form to:**  
 AACN  
 101 Columbia  
 Aliso Viejo, CA 92656-4109  
 Fax (949) 362-2020

**or call:**  
 (800) 899-2226 (in the U.S.)  
 (949) 362-2050

**Join online at:**  
[www.aacn.org](http://www.aacn.org)

**MARKET CODE: APMBWB**

Product #2022

The AACN membership list is sold periodically to organizations that wish to send information regarding various educational courses, publications and other products or services that are presumed to be of interest to critical care practitioners. AACN carefully screens all such requests to ensure that these offerings are appropriate and in good taste. If you do not want us to provide your name to other companies for the purpose of receiving these marketing offers, please check here:  Please do not include my name on such lists sold to other organizations.