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AAMN Membership Application

Questions? Feel free to contact us: Telephone 205-956-0146 Fax 205-956-0149 Email [aaamn@aamn.org](mailto:aamn@aamn.org)

Please Check One: New Member Renewal Member

Personal Information: Please print legibly

First Name: _____ M.I. _____ Last Name: _____

Preferred Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Preferred Contact Telephone Number: _____ Alternate Telephone Number: _____

Preferred Email Address: _____ Alternate Email: _____

(Please note that we use a mass email server to reach many members at once. Some University and Work email servers block this. Please provide us with an alternate email address if your primary email is through work or school)

Demographic Information

- Ethnicity** **Year of Birth**
- American Indian/Alaskan Native 19____
- Asian
- Black/African American **Sex**
- Caucasian Female
- Native Hawaiian/ Pacific Islander Male
- Hispanic Ethnicity

Chapter Participation

- Are you a member of a Local Chapter?**
- Yes
- No
- If yes, name and location of Chapter?**
- _____
- If no, interested in Local Chapter Participation and/or Creation?**
- Yes
- No

Education Information

- Highest Degree Earned (Select One)**
- Doctorate
- Post-Masters
- Master's
- Bachelor's
- Bachelor's w/ Certificate
- Associate's w/ Certificate
- Diploma w/ Certificate
- (Projected) Year of Nursing Degree Completion _____
- List current certifications: _____

Student Information

Name of School: _____

City: _____ State: _____

Program Specialty: _____

Professional Information

- Areas of Study**
(Circle main area of study, check any other)
- Acute Care Oncology
- Adult Care Pediatrics
- Clinical Research Mental Health
- Family Care Surgical
- Geriatrics Trauma/Critical Care
- Men's Health Women's Health
- Neonatal Other: _____

Types of Practice Roles Performed

- (Please choose all that apply)
- Administration
- Clinical Practice
- Faculty
- Research
- Military (active/retired)
- Other: _____

Payment Information

Membership Fees: Full RN \$80 Transitional (1st year working as RN) \$35* LPN/LVN \$40 Retired/Disabled Nurse \$40 Nursing Students \$25**

- *Copy of licensure required for transitional or LPN/LVN discount **Proof of enrollment required for student discount

Mail application with payment to: American Assembly for Men in Nursing PO Box 130220 Birmingham, AL 35213

Enclosed is my check payable to the American Assembly for Men in Nursing

Please charge to my credit card Visa Master Card Please consider a \$20 Donation to AAMN Scholarship Fund \$ _____

Card Number: _____ Exp Date __/__/____ Total Amount \$ _____

Name on Card: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Signature: _____ Date: _____