



WWW.AAMN.ORG

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

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
- Year of Nursing Degree Completion**
- ____ (Projected year if still in school)

Student Information

Name of School: _____

City: _____ State: _____

Degree program: _____

Professional Information

- Areas of Study**
- (Please CIRCLE your Main Area of study, check any others)*
- 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 your MAIN practice role)*
- Administration
 - Clinical Practice
 - Faculty
 - Research
 - Military (active/retired)
 - Other: _____

Payment Information

- Membership Fees:** Full RN \$100 Transitional (1st year working as RN) \$50* LPN/LVN \$50
- *Copy of licensure required for transitional or LPN/LVN discount*
- Retired/Disabled Nurse \$50 Nursing Students \$30** NSNA Member Nursing Student \$25** _____
- **Proof of enrollment required for student discount (NSNA Membership ID#)*

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 or Please charge to my credit card Visa Master Card

Please consider a \$20 Donation to AAMN Scholarship Fund \$ _____

Card Number: _____ Exp Date ____ / ____ Total Amount to be Charged \$ _____

Name on Card: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Signature: _____ Date: _____