American Academy of Ambulatory Care Nursing

Shaping Care Where Life Happens

Membership Form

Please provide your cell phone number to receive text timely messages. We will not send more than 6 text messages per year.

Membership ID#: _____

Name: _____

Credentials: _____

Address: _____ ☐ Home ☐ Work

City: _____ State: _____ Zip: _____

E-mail Address: _____

Employer: _____

Preferred Phone: (_____) _____ ☐ Cell ☐ Work

Date of Birth: _____

***SAVE TIME* – Join AAACN online at aaacn.org**

DATA QUESTIONS

Please check one answer for each question.

1. Position
- ☐ Vice President
- ☐ Chief Nursing Officer/Executive
- ☐ Administrator/Director
- ☐ Advanced Practice Nurse-APRN
- ☐ Care Coordinator
- ☐ Consultant
- ☐ Patient/Staff Educator
- ☐ Manager/Supervisor
- ☐ Payor Care Manager
- ☐ Academia/Researcher
- ☐ Staff Nurse
- ☐ Other _____

2. Employment Setting
- ☐ College/Higher Educational Institution
- ☐ Community Hospital
- ☐ Ambulatory Free-Standing Facility
- ☐ FQHC
- ☐ Hospital-based Outpatient Clinic/ Center
- ☐ Integrated Healthcare System
- ☐ Managed Care/HMO/PPO
- ☐ Military or VA
- ☐ MSO/ACO/CIN
- ☐ Solo/Independent Physician Practice
- ☐ Telehealth Call Center
- ☐ Academic Medical Center
- ☐ Other _____

3. Highest Level of Education Completed
- ☐ LPN/LVN
- ☐ Diploma in Nursing
- ☐ Associate Degree in Nursing
- ☐ Associate Degree in Other Field
- ☐ Bachelor's Degree in Nursing
- ☐ Bachelor's Degree in Other Field
- ☐ Master's Degree in Nursing
- ☐ Master's Degree in Other Field
- ☐ PhD in Nursing
- ☐ Doctor of Nursing Practice (DNP)
- ☐ Education Doctorate (EdD)
- ☐ Doctorate Degree in Other Field

4. Please select the ONE area that best describes your area of practice or area of responsibility.
- ☐ Ambulatory Surgery
- ☐ Community/Public Health
- ☐ Family Practice
- ☐ General Surgery/Surgical Specialties
- ☐ Informatics/Technology
- ☐ Insurance Company/Managed Care
- ☐ Internal Medicine
- ☐ Medical Specialties
- ☐ Multispecialty Clinic
- ☐ Pediatrics
- ☐ Physcian Group Office Practice/ Primary Care
- ☐ Specialty/Sub-Specialty Physician Practice
- ☐ Telehealth/Telephone Triage
- ☐ Urgent/Immediate Care Center
- ☐ Women's Health
- ☐ Other _____

6. Are you Certified? (Check all that apply)
- ☐ Ambulatory Nursing ANCC
- ☐ Care Coordination
- ☐ Telehealth NCC

7. Select the journal you would like to receive as part of your membership benefits.
- ☐ *MEDSURG Nursing*
- ☐ *Nursing Economic$*
- ☐ *Pediatric Nursing*

8. How did you hear about AAACN?
- ☐ AAACN member
- ☐ AAACN Conference
- ☐ Another Conference
- ☐ Certification organization
- ☐ Colleague who is not a AAACN member
- ☐ Nursing journal or publication
- ☐ Social Media
- ☐ Website

9. Select how you will receive your *ViewPoint* newsletter
- ☐ By Email
- ☐ By Mail

10. What is your birthday month:

_____

11. What is your birthday year:

_____

12. Who referred you to AAACN?

_____

MEMBERSHIP DUES

Registered Nurse (1 year) $150.00

Registered Nurse (2 years) $280.00
Pay 2 years – SAVE $20

Affiliate/LPN/LVN $125.00

Senior $70.00
(Continuous member for 3 years and reached age 62)

Student $70.00
(Course of study for initial licensure ONLY – enclose proof of enrollment)

_____

☐ Check is enclosed (payable in US Funds to AAACN)

☐ Charge my ☐ VISA ☐ MC ☐ AMEX

Amount $ _____ Exp. _____ /_____

Name on card: _____

Account #: _____

Card security code: _____

(3-digit code found on back of Visa & Mastercard;
4-digit code front of American Express)

Billing Address (Street # only) _____

Billing Zip Code _____

Signature: _____

Thank you for renewing your AAACN membership.

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