Clinical Nurse Leader Association

Membership Application

Please provide the contact information that you wish to appear in the CNLA directory. Return this form, to the CNLA National Office if paying by check (make payable to CNLA). Send to **AACN, PO Box 418350, Boston, MA 02241-8350** or FAX with credit card info to **1-202-463-1315**, PHONE 1-202-463-6930 extension 267
E-MAIL- info@cnlassociation.org or cnla@aacn.nche.edu.

NAME _____ CREDENTIALS _____

HOME ADDRESS _____ CITY _____ STATE ____ ZIP _____

( ) HOME PHONE _____ PREFERRED MAILING ADDRESS ☐ Home ☐ Work

PLACE OF EMPLOYMENT _____ E:MAIL ADDRESS _____

WORK ADDRESS _____ CITY _____ STATE ____ ZIP _____

EMPLOYMENT STATUS ☐ Full-time ☐ Part time ☐ Unemployed ☐ Retired ☐ Student

PRIMARY PRACTICE SETTING ☐ Hospital ☐ Public Health/Community Nursing ☐ Home Care ☐ School of Nursing

☐ Hospice ☐ MD Office ☐ Long-term Care ☐ Outpatient/Amb Care ☐ Other _____

MAILING LIST EXCLUSION

☐ Please check here if you do NOT want your name and address included on the CNLA mailing list.

New Membership ☐

Renewal ☐

New members will receive a confirmation email with information regarding access to the member areas of our web site (www.cnlassociation.org) and a new member certificate with your member ID number. Please make sure you register on line and keep a record of your sign on information.

Membership dues are not tax deductible as a charitable contribution. They may be deductible as an ordinary and necessary business expense. Consult your tax advisor for information

Enrollment form must accompany payment. Please direct any questions to the e-mail address above.

MEMBERSHIP CATEGORIES:

☐ Clinical Nurse Leader®.....$150.

☐ Clinical Nurse Leader® Student*.....$100.

☐ Practice partners & Educators.....$125.

*Includes CNL graduates awaiting certification. Please submit a copy of current student ID card.

Method of Payment

☐ Check # _____(enclosed). Amount _____
Make payable to American Association of Colleges of Nursing.
**A charge of $25 will apply to checks returned for insufficient funds.*

☐ *Check to be mailed by member's employer*

☐ Visa ☐ MasterCard Amount _____

**If rebilling of a credit card charge is necessary, a $25 processing charge will be necessary.*

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Credit Card Account Number

X _____ ☐☐ - ☐☐
Signature Expiration Date