

THE CARIBBEAN AMERICAN NURSES ASSOCIATION, INC.



MEMBERSHIP APPLICATION FORM

PART I – BIOGRAPHICAL DATA

- A. Name \_\_\_\_\_
- B. Address (Street) \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_
- C. Telephone \_\_\_\_\_
- D. Place of Employment \_\_\_\_\_  
 Telephone \_\_\_\_\_

PART II – EDUCATIONAL DATA

- A. Professional
  - a. School of Nursing \_\_\_\_\_
  - b. Highest Degree Held \_\_\_\_\_
- B. Areas of Employment
 

<input type="checkbox"/> Clinical	<input type="checkbox"/> Staff Development	<input type="checkbox"/> Other (Specify)
<input type="checkbox"/> Administration	<input type="checkbox"/> School of Nursing	_____
<input type="checkbox"/> Education	<input type="checkbox"/> College/ University Setting	
- C. Areas of Specialization (Please Indicate)  
 \_\_\_\_\_

PART III – STANDING COMMITTEES (Select one willing to serve on).

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> EDUCATION                        | <input type="checkbox"/> NOMINATING   |
| <input type="checkbox"/> HEALTH FAIR/ COMMUNITY ACTIVITES | <input type="checkbox"/> PROFESSIONAL |
| <input type="checkbox"/> SOCIAL ACTION                    | <input type="checkbox"/> NEWSLETTER   |

PART IV – RECOMMENDED BY: \_\_\_\_\_

PART V – REGISTRATION INFORMATION

Registration Fee: \$15.00 (payable at time of application)  
 Annual Dues: \$50.00 individual membership; \$100.00 organization

PART VI – ACCEPTED AS MEMBER ON: \_\_\_\_\_