



South Carolina League for Nursing MEMBERSHIP APPLICATION

NAME: _____

HOME ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE: Home: (____) _____ Work: (____) _____

FAX: Home: (____) _____ Work: (____) _____

E-MAIL: Home: _____ Work: _____

POSITION/TITLE: _____

PLACE OF EMPLOYMENT: _____

STREET ADDRESS: _____

CITY/STATE/ZIP: _____

PREFERRED MAILING ADDRESS: Home Work

PREFERRED E-MAIL ADDRESS: Home Work

MEMBERSHIP CATEGORIES (Select one) Membership year is January 1 – December 31.

Individual	\$30.00
Consumer.....	\$30.00
Student (undergraduate or graduate).....	\$5.00
Retired	\$15.00

All categories above include SCLN voting membership, SCLN annual meeting, and more.

METHOD OF PAYMENT

Check or money order made payable to the South Carolina League for Nursing.

Send signed application and remittance to:

Sarah Roland
SCLN, Membership Chair
4100 Byrnes Blvd
Florence, SC 29506

All membership applications must be signed to comply with postal regulations.

Signature: _____

Date: _____