Please complete and mail/fax with payment to:
The National League for Nursing
Attn: Membership
2600 Virginia Avenue, NW, 8th Floor
Washington, DC 20037
Fax: (202) 944-8523

(Please print)

Organization/Agency ________________________________________________

Street ____________________________________________________________

City/State/Zip ______________________________________________________

Telephone _______________ Fax _______________ Website __________________

Name of primary representative to whom mail is to be directed ________________

Position/title _______________Credentials _______________Preferred Prefix _______________

Mailing address if other than above ______________________________________

Email ___________________________ Phone ____________________________

Name to whom second membership is to be directed ______________________

Position/title _______________Credentials _______________Preferred Prefix _______________

Mailing address if other than above ______________________________________

Email ___________________________ Phone ____________________________

NLN Associate Fee
The membership period is January to December. Select either single site or multiple sites.

☐ Single Site… $566  ☐ Multiple Sites… $566+ (# of additional sites ___) x $200 = Total enclosed ____

Payment Information

☐ Check payable to the National League for Nursing is enclosed

☐ Charge my credit card: ☐ American Express ☐ Discover ☐ Mastercard ☐ VISA

Card number _______________________________ Expiration Date _________________________

Name as it appears on card (print) _______________________________ Signature _______________________

Complete and sign next page

ADDITIONAL SITES  ☐ None
(If more than two attach separate sheet)

1. Name of Primary Contact: ________________________________
   Position/Title ________________________________
   Mailing Address ________________________________
   Email ________________________________ Phone ________________________________

2. Name of Primary Contact: ________________________________
   Position/Title ________________________________
   Mailing Address ________________________________
   Email ________________________________ Phone ________________________________

Select One:

☐ I understand that as an NLN Associate member my organization/agency’s name and web address will be listed on the NLN Associate directory of the NLN website as it appears above.

☐ I do not want to be included in the directory of NLN Associate members on the NLN website.

* * * * * * * * * * * * * * * * * * * * * * * * * *

I understand that $8.50 of my dues is for my subscription to Nursing Education Perspectives

__________________________________________________________________________  __________________________________________________________________
Signed                                                                 Date