

**FMRNA** Membership Application

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Degree/s: \_\_\_\_\_

Program Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone (work): \_\_\_\_\_ Fax (work): \_\_\_\_\_

Phone (home): \_\_\_\_\_

E-mail: \_\_\_\_\_

Number of years in present position: \_\_\_\_\_

Please list your areas of expertise or special interest and tell us if you are willing to share information: \_\_\_\_\_

Would you like to be added to the FMRNA e-mail discussion list:

Yes  No

**I am applying for:**

- Active membership (\$75/year) (RN, LPN, NP)
- Associate membership (\$30/year) (MA, NA)

I am a:  renewing  new member.

Signature of applicant \_\_\_\_\_

Date \_\_\_\_\_

Check enclosed in the amount of \$\_\_\_\_\_ **Please make check payable to "FMRNA"**

Or charge the amount to my:  MasterCard  VISA

Card No. \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please return your completed membership application to:

FMRNA  
Attention: Pat Goranflo  
11400 Tomahawk Creek Parkway  
Leawood, KS 66211-2672  
1-800-274-2237, ext. 6706  
E-mail: pgoranfl@aafp.org

For office use only: Check #: \_\_\_\_\_

Date check received \_\_\_\_\_

