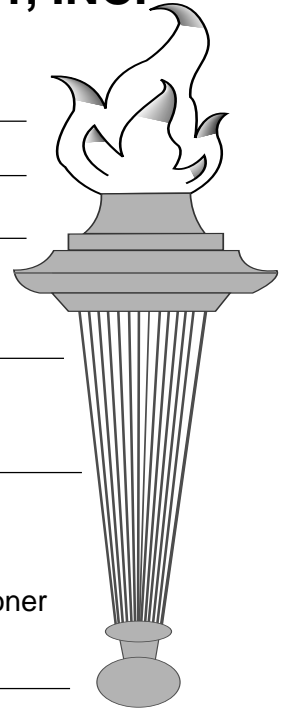


# ASSOCIATION OF BLACK NURSING FACULTY, INC.

Membership Application/Renewal Form and Dues Statement  
Payment extends from January 1 to December 31 of the current year



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

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

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

Telephone: Home: \_\_\_\_\_

Work: \_\_\_\_\_ FAX: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Position/Title: \_\_\_\_\_

## HIGHEST DEGREE (check one):

- |                                     |   |
|-------------------------------------|---|
| <input type="checkbox"/> 01 PhD     | <input type="checkbox"/> 04 Bachelors                   |
| <input type="checkbox"/> 02 EdD     | <input type="checkbox"/> 05 Advanced Nurse Practitioner |
| <input type="checkbox"/> 03 Masters | <input type="checkbox"/> 06 Other: Please Specify _____ |

YEAR OF HIGHEST DEGREE: \_\_\_\_\_

## AREA OF SPECIALIZATION (check one only):

- |   |  |
|---|--|
| <input type="checkbox"/> 01 Obstetrics            | <input type="checkbox"/> 06 Medical-Surgical               |
| <input type="checkbox"/> 02 Pediatrics            | <input type="checkbox"/> 07 Public Health/Community Health |
| <input type="checkbox"/> 03 Maternal-Child Health | <input type="checkbox"/> 08 Psychiatric/Mental Health      |
| <input type="checkbox"/> 04 Medical               | <input type="checkbox"/> 09 Fundamentals                   |
| <input type="checkbox"/> 05 Surgical              | <input type="checkbox"/> 10 Other: _____                   |

## MAJOR RESPONSIBILITY:

- |   |
|---|
| <input type="checkbox"/> 01 Undergraduate Program       |
| <input type="checkbox"/> 02 Graduate Program            |
| <input type="checkbox"/> 03 Other: Please Specify _____ |

## ABNF COMMITTEES (please select no more than two):

- |   |  |
|---|--|
| <input type="checkbox"/> 01 By-Laws       | <input type="checkbox"/> 05 Program                |
| <input type="checkbox"/> 02 Finance       | <input type="checkbox"/> 06 Research               |
| <input type="checkbox"/> 03 Publication   | <input type="checkbox"/> 07 State Coordinators     |
| <input type="checkbox"/> 04 Public Policy | <input type="checkbox"/> 08 Ad Hoc: Annual Meeting |

## QUESTIONS:

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 1. Are you a member of the following organizations?             | <b>YES</b>               | <b>NO</b>                |
| American Nurses Association                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| National League for Nursing                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| National Black Nurses Association                               | <input type="checkbox"/> | <input type="checkbox"/> |
| Chi Eta Phi   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Would you like to serve as State Coordinator for your state? | <input type="checkbox"/> | <input type="checkbox"/> |

MEMBERSHIP DUES:  \$100.00  Students \$25.00

Contribution/Donation to ABNF Foundation:  \$25.00  \$50.00  \$75.00  Other \_\_\_\_\_

TOTAL ENCLOSED: \_\_\_\_\_

**Make check payable to ABNF and return to:**

Kimetha Broussard • 6704 NW Westaire Cr. • Lawton, OK 73505

This member was recruited by: \_\_\_\_\_