



National Organization of Nurse Practitioner Faculties

900 19th Street, NW, Ste. 200B, Washington, DC 20006

Tel. (202) 289-8044 Fax: (202) 384-1444 E-mail: nonpf@nonpf.org

APPLICATION FOR PROGRAM (GROUP) MEMBERSHIP*

Membership Year: September 1, 2011 - August 31, 2012

Name of Program: _____

Director of Program: _____

Program Address: _____

Program Phone #: _____ Fax #: _____

Location of Program (Select One): School of Nursing School of Medicine Other: _____

Does your institution have an Academic Nursing Center? Yes No

Names and email addresses of 4 faculty members to be covered by group membership fee (\$700.00):

1. _____ 3. _____
2. _____ 4. _____

Names and email addresses of additional faculty to be covered by \$130 per person (copy this page if more than 4 additional):

5. _____ 7. _____
6. _____ 8. _____

SIG Membership (Optional): Members may join one or more of the special interest groups (SIGs) to engage in targeted discussion and activities with other faculty. Additional membership fee of \$15 per SIG per faculty member. Please identify the corresponding letter of the SIG by the name of any faculty listed above who wish to join a SIG.

Academic Nursing Center = N Acute Care = A Distance Learning = D Gerontological = G International = I Program Directors = Y Psych-Mental Health NP = P Research = R Sexual & Reproductive Health = S

Additional SIG payment: _____

“Drive to the Future” Giving Campaign: _____

TOTAL MEMBERSHIP FEE: _____

METHOD OF PAYMENT:

- Check or money order payable to NONPF
 - Master Card or VISA credit card payment
- Name on Card: _____
Card #: _____
Card Security Code (3-Digit number from back of card) _____
Expiration Date: _____

RETURN APPLICATION AND PAYMENT TO: NONPF, 900 19th Street, NW, Ste. 200B, Washington, DC 20006

** Program membership is available to all nurse practitioner educational programs. Each nurse faculty member for whom dues are paid under the program membership shall have one vote, is eligible to hold an elected position, receives membership communications, and receives membership discounts.*

COMPLETE PROFILE FORM ON REVERSE SIDE FOR EACH FACULTY REPRESENTATIVE

PROFILE OF FACULTY IN PROGRAM (GROUP) MEMBERSHIP

**Please have each faculty member complete the following profile questions.
(Reproduce for additional copies)**

Name: _____

Preferred Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Tel: _____ Fax: _____ E-mail: _____

Title/Position: _____

Are you full-time or part-time faculty? _____

Your highest level of education:

Baccalaureate Master's Doctorate Post-Master's

Other (specify): _____

Number of years in current teaching position: _____

What year did you become a nurse practitioner: _____

NP Specialty area of practice (e.g., family): _____

If not an NP, please specify your APRN or other health care role: _____

Do you practice clinically? 1. Yes 2. No

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1. As part of teaching job

2. As a separate (paid) job

3. Other (specify) _____

Approximate number of hours per week in clinical practice: _____

Please describe your practice setting and type of practice: _____

Are you involved in research activities? 1. Yes 2. No

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What is your current project? _____

Please answer the following questions to help us track the diversity of our membership.

Gender: Female Male

Year of birth: _____

Please identify your race/ethnicity. Select one or more as appropriate.

American Indian or Alaska Native Asian Black or African American

Hispanic or Latino Native Hawaiian or other Pacific Islander White

OPTIONAL: Special Interest Groups Mark which SIGs you wish to join (**\$15 fee per SIG**)

Academic Nursing Center Acute Care Distance Learning Gerontological

International Program Director Psychiatric-Mental Health Research Sexual and Reproductive Health