MASSACHUSETTS COALITION
M·C·N·P
OF NURSE PRACTITIONERS

MCNP Group Membership Application

This application is by and between the MCNP and the organization listed below. The MCNP agrees to provide the selected Group Membership benefits for a term of 1 year as detailed in the MCNP Group Membership Structure.

Organization Name: _____

Contact Person: _____ Title: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

E-mail: _____

[ ] Platinum Package Group Membership: $10,000

[ ] Gold Package Group Membership: $7,500

[ ] Silver Package Group Membership: $5,000

[ ] Bronze Package Group Membership: $2,500

[ ] Copper Package Group Membership: $1,000

By completing this application and signing below, the individual attests that they are an authorized representative of the **Group Member** organization.

Signature: _____Date: _____

Title: _____

Once your Group Membership application has been processed, you will be provided with a group membership code that your APN employees can use to register as MCNP members. Upon registration with this code, employment status with your organization will be verified, and membership will be valid for 1 year. You will also be asked for a file copy of your organizational logo for posting on our website.

Please email editor@mcnpweb.org or call 781-575-1565 with any questions about Group Membership or completing this form. Please make check made payable to **Massachusetts Coalition of Nurse Practitioners** and return with this completed form to:

MCNP
PO Box 1135
Littleton, MA 01460