Membership Application

Federal ID # 20-0685642

1120 Route 73, Suite 200
Mount Laurel, NJ 08054
Phone: 888-45-AAHFN
Fax: 856-439-0525
Website: www.aahfn.org
Email:information@aahfn.org

Please check one: ❒ New ❒ Renewal

Please update Name and Address Below:	
Name:	Phone:
Address:	Fax:
Address 2:	Email:
City: State:	Credentials:
Zip code Country	License #
Referred by (AAHFN Member):	
Employer:	

Select Membership (*Category descriptions available at aahfn.org)*

Must be a Nurse (RN) to join as an Active or International Member.			**LVN, LPN, non-nurse Professional and students are eligible to join as a Corporate, Associate or Student Member.**	
Active ❒ 1 year $95	**International** ❒ 1 year $110	**Emeritus** ❒ 1 year $85	**Associate** ❒ 1 year $75	**Student** ❒ 1 year $75

***Please note that $22.50 of your annual dues for membership is for a one-year subscription to *Heart & Lung: the Journal of Acute and Critical Care*.**

1. Certifications:

❒ ACNP ❒ CHFN
❒ ANP ❒ FNP
❒ CCNS ❒ PCCN
❒ CCRN ❒ Other____

2.Highest nursing degree:

❒ Diploma ❒ Masters
❒ Associate ❒ Doctorate
❒ Bachelors

3.Age Range:

❒ 21 and under ❒ 55-64
❒ 22-34 ❒ 65 and over
❒ 35-44 ❒ Decline
❒ 45-55

4. Practice Setting/Location?

❒ Urban(> 1000 people per square mile or total population > 50,000)
❒ Rural (areas comprise open country and settlements with fewer than 2,500 residents)
❒ Suburban (a metropolitan area outside the central city)

5. I work in a:

❒ Case Management/HMO/Insurance
❒ Heart Failure Program - Inpatient (hospital based)
❒ Heart Failure Program - Outpatient (hospital based)
❒ Heart Failure Program - Both Inpatient & Outpatient (hospital based)
❒ Heart Failure Program - Private Practice
❒ Home Health
❒ Hospital - staff nurse
❒ Private Practice Office - Cardiology
❒ Private Practice Office - Internal Medicine/Family Practice
❒ Research
❒ University/Academics
❒ Other_____

6. Years of nursing experience_____

7. Years of heart failure experience_____

8. I would like to be listed in the member directory:

❒ Yes ❒ No

9. Do you have prescriptive privileges?

❒ Yes ❒ No

Payment Information

Check: Make payable to AAHFN and enclose with invoice, send to address listed above.

Credit Card ❒Visa ❒MasterCard ❒AMEX

Credit Card Number_____ Expiration Date _____

Name on Card _____ Signature _____