



# 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](http://www.aahfn.org)  
 Email: [information@aahfn.org](mailto: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](http://aahfn.org))

<b>Must be a Nurse (RN) to join as an Active or International Member.</b>			<b>LVN, LPN, non-nurse Professional and students are eligible to join as a Corporate, Associate or Student Member.</b>	
<b>Active</b> <input type="checkbox"/> 1 year \$105	<b>International</b> <input type="checkbox"/> 1 year \$120	<b>Emeritus</b> <input type="checkbox"/> 1 year \$95	<b>Associate</b> <input type="checkbox"/> 1 year \$85	<b>Student</b> <input type="checkbox"/> 1 year \$85

\*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
- ANP
- CCNS
- CCRN
- CHFN
- FNP
- PCCN
- Other \_\_\_\_\_

#### 2. Highest nursing degree:

- Diploma
- Associate
- Bachelors
- Masters
- Doctorate

#### 3. Age Range:

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

#### 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 \_\_\_\_\_

CVV Number \_\_\_\_\_

Name on Card \_\_\_\_\_ Signature \_\_\_\_\_