

ABNS
American Board of Nursing Specialties

Promoting Excellence in Nursing Certification

Associate Member Application

For office use only
Date received:

Associate Membership is open to specialty health care certification organizations that certify Registered Nurses as a portion (50% or less) of their certificant population. Please attach a document that states the organization's mission and purpose(s).
Total Number Certified _____ Percentage Registered Nurses _____ Percentage Other _____

ALL INFORMATION PROVIDED IS SUBJECT TO PRINTING IN THE ORGANIZATIONAL DIRECTORY UNLESS OTHERWISE REQUESTED

Name of Organization

Mailing Address

City

State

Zip Code

Office Phone Number

Office Fax Number

E-mail Address

Website Address

Contact Person's Name, Credentials, and Organizational Title

Please list the names and contact information (where mail should be sent) for up to two (2) Organizational Representatives to ABNS. The first name listed will be considered the primary contact.

1. First Representative's Name, Credentials **Title**

Address

City

State

Zip Code

Phone Number

Fax Number

E-mail Address

Website Address

2. Second Representative's Name, Credentials **Title**

Address

City

State

Zip Code

Phone Number

Fax Number

E-mail Address

Website Address

Yearly Membership Dues are \$1,500.00

Dues are prorated based on the quarter in which you join.

Please return this application and check (payable to ABNS) to:
ABNS
610 Thornhill Lane, Aurora, OH 44202
Phone: 330.995.9172 Fax: 330.995.9743
E-mail: ABNSCEO@aol.com