

Connecticut Association of Public Health Nurses

Membership Form

Name: _____

Job Title: _____

Agency: _____

Preferred Mailing Address: Business Home

Street: _____

City: _____

State: _____ Zip: _____ - _____ (Plus 4)

Phone: () _____ Fax: () _____

E-mail: _____@_____

YES! I want to join CAPHN listserv.

YES! You may share my information with other professional organizations.

Membership Categories & Dues

2008 – 2009 Membership Fees

\$35.00 Regular Member – Registered Nurse currently or formerly engaged in public health nursing practice, education or policy.

\$20.00 Associate Member – An individual with an interest in public health nursing in Connecticut.

I would like to serve on the following committee(s).

Finance

Membership

Practice

Program

A brief description of each committee is available on the CAPHN website at www.caphn.org

Send in completed membership form with a check payable to CAPHN:

**Mail to: CAPHN
c/o CT Nurses Association
377 Research Parkway, Suite 2D
Meriden, CT 06450
or Fax: 203-238-3437**