

**ABNS**  
**American Board of Nursing Specialties**  
*Promoting Excellence in Nursing Certification*  
**Regular Member Application**

*For office use only*  
Date received:

**Regular Membership** is open to specialty nursing certification organizations that certify Registered Nurses exclusively, or as the major portion of their certificant population (51% or more). 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. Please note which of the representatives will be the voting representative.**

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

Address

City

State

Zip Code

Phone Number

Fax Number

E-mail Address

Website Address

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

Address

City

State

Zip Code

Phone Number

Fax Number

E-mail Address

Website Address

**Annual Membership Fee:  
\$2,000.00 Dues are prorated based  
on 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