For office use only
Date received:

ABNS
American Board of Nursing Specialties

Promoting Excellence in Nursing Certification

Regular Member Application

Regular Membership is open to specialty certification organizations that certify Registered Nurses.

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.

ABNS
3416 Primm Lane, Birmingham, AL 35216
Phone: 205-795-7127
E-mail: abns@nursingcertification.org

Please return this application and check (payable to ABNS) to: