



Kentucky Coalition of Nurse Practitioners & Nurse Midwives

Membership Application

Name _____ Credentials _____

Preferred Mailing Address: _____

City _____ State _____ Zip _____

Primary Phone: (____) _____ Work: (____) _____

Fax: (____) _____ Email: _____

Highest degree earned: _____ County of Residence: _____

If Student: University _____ Expected Graduation Date _____

Practice Information for Directory: (ARNPs only)

Practice: _____

Address: _____

City _____ State _____ Zip _____

Specialty/Sub-Specialty (if applicable) _____

County in which you practice: _____

Please circle

Yes No I agree to have my name released for mailing lists

Yes No Include me in the directory published each June

Annual Membership Dues: Renewal Rates

Active-renewal	_____	\$95.00 (KY ARNP)
Active Non-Resident	_____	\$85.00 (Non-KY ARNP)
Associate	_____	\$50.00 (Non-ARNP)
Student-renewal	_____	\$25.00 (Enrolled at _____)
Retired	_____	\$25.00 (62+ and not employed full time)

New and Student Members:

New Active	_____	\$50.00 for 1 st time ARNP members (KY and out of state)
New Student	_____	Free your first year (Kentucky Universities)
New Associate	_____	\$50.00 (Non-ARNP)
New Graduate	_____	\$50.00 for recent graduates (KY and out of State)
New Retired	_____	\$25.00 (62+ and not employed full time)

I'm adding ___\$25___\$10___\$_____ for the Ellen Bailey Memorial Fund

Mail completed form and check to:

KCNPNM
1017 Ash St.
Louisville, KY 40217