



2018 MEMBERSHIP APPLICATION
(COMPLETE FORM OR REGISTER ONLINE AT WWW.MICNP.ORG)

<input type="checkbox"/> NEW MEMBER			<input type="checkbox"/> RENEWAL		
APPLICANT INFORMATION					
Name:			Nursing License #:		
Home address:					
City:		State:		Zip Code:	
Phone:			Personal Email:		
WORK INFORMATION					
Employer:					
Employer address:					
City:		State:		Zip Code:	
Work Phone:			Work Email:		
PREFERRED EMAIL FOR MICNP COMMUNICATION (WILL DEFAULT TO PERSONAL IF NOT CHECKED): <input type="checkbox"/> PERSONAL <input type="checkbox"/> WORK					
Please Select Chapter:					Student Affiliate Chapter: (additional dues w/student chapter apply)
<input type="checkbox"/> ANN ARBOR	<input type="checkbox"/> CAPITAL AREA	<input type="checkbox"/> CENTRAL (Mt. Pleasant)	<input type="checkbox"/> EASTERN UP	<input type="checkbox"/> MSU	<input type="checkbox"/> Oakland
<input type="checkbox"/> FLINT	<input type="checkbox"/> GREATER GRAND RAPIDS	<input type="checkbox"/> LAKESHORE (Holland)	<input type="checkbox"/> METRO (Detroit)	<input type="checkbox"/> UofD Mercy	<input type="checkbox"/> UofM - AA
<input type="checkbox"/> NAPNN (UP)	<input type="checkbox"/> NORTHEAST (Alpena)	<input type="checkbox"/> NORTHWEST (formerly Petoskey)	<input type="checkbox"/> SOUTHWEST (Kalamazoo area)	<input type="checkbox"/> UofM - Flint	<input type="checkbox"/> Wayne State
<input type="checkbox"/> TRAVERSE AREA	<input type="checkbox"/> TRI-CITIES (Bay City, Saginaw, Midland)				
			Student members only: School Attending: _____		Student members only: Grad Date (MM/YYYY): _____
Highest Degree You Currently Hold			Specialty		
<input type="checkbox"/> BSN	<input type="checkbox"/> MSN	<input type="checkbox"/> MS	<input type="checkbox"/> PhD	<input type="checkbox"/> DNP	
<input type="checkbox"/> ACNP	<input type="checkbox"/> ANP	<input type="checkbox"/> CNM	<input type="checkbox"/> FNP	<input type="checkbox"/> GNP	<input type="checkbox"/> MHNP
<input type="checkbox"/> NNP	<input type="checkbox"/> PMHNP	<input type="checkbox"/> PNP	<input type="checkbox"/> WHNP	<input type="checkbox"/> Student	<input type="checkbox"/> Other: _____
Practice Area: (Complete list available online)			Indicate your work setting:		
<input type="checkbox"/> Adult/Primary Care	<input type="checkbox"/> HIV/Aids	<input type="checkbox"/> Ophthalmology	<input type="checkbox"/> Administration	<input type="checkbox"/> Nurse Managed Center	
<input type="checkbox"/> Allergy/Immunology	<input type="checkbox"/> Infectious Disease	<input type="checkbox"/> Pain Management	<input type="checkbox"/> Community Based Clinic	<input type="checkbox"/> NP Owned Practice	
<input type="checkbox"/> Cardiology	<input type="checkbox"/> Internal Medicine	<input type="checkbox"/> Palliative Care	<input type="checkbox"/> Correctional Facility	<input type="checkbox"/> Occupational Health	
<input type="checkbox"/> Dermatology	<input type="checkbox"/> Mental Health	<input type="checkbox"/> Pediatrics	<input type="checkbox"/> Family Planning Center	<input type="checkbox"/> Physician Owned Practice	
<input type="checkbox"/> Endocrinology	<input type="checkbox"/> Neonatal	<input type="checkbox"/> Pulmonary	<input type="checkbox"/> Health Department	<input type="checkbox"/> Retail Clinic	
<input type="checkbox"/> ENT	<input type="checkbox"/> Nephrology	<input type="checkbox"/> Rheumatology	<input type="checkbox"/> Home Health / Hospice	<input type="checkbox"/> Retired	
<input type="checkbox"/> Family Practice	<input type="checkbox"/> Neurology	<input type="checkbox"/> Sports Medicine	<input type="checkbox"/> Hospital	<input type="checkbox"/> School/University	
<input type="checkbox"/> Gastroenterology	<input type="checkbox"/> OB/GYN	<input type="checkbox"/> Urology	<input type="checkbox"/> Long-term Care	<input type="checkbox"/> Urgent Care/ER Dept	
<input type="checkbox"/> Geriatrics	<input type="checkbox"/> Oncology/Hematology	<input type="checkbox"/> Women's Health	<input type="checkbox"/> N/A - Student	<input type="checkbox"/> Veterans Administration	
I AM WILLING TO BE CONTACTED AS A CLINICAL CONSULTANT				<input type="checkbox"/> YES <input type="checkbox"/> NO	
I AM WILLING TO BE AN EXPERT WITNESS				<input type="checkbox"/> YES <input type="checkbox"/> NO	
I AM ACCEPTING NEW PATIENTS & AM WILLING TO BE CONTACTED BY THE PUBLIC				<input type="checkbox"/> YES <input type="checkbox"/> NO	
I WANT TO BE INCLUDED IN THE MEMBER DIRECTORY				<input type="checkbox"/> YES <input type="checkbox"/> NO	
How did you hear about MICNP?			Referred by:		
Signature of applicant:				Date:	
REGULAR MEMBERSHIP DUES: \$175 annually		Send Checks to:		** When paying by check, membership is not considered active or renewed until payment is received **	
STUDENT MEMBERSHIP DUES: \$50 annually (RNs currently enrolled in a graduate Nursing/NP Track University)		MICNP			
RETIRED MEMBERSHIP DUES: \$50 annually (Retired or over 65)		PO Box 87934 Canton, MI 48187			