



HPNA Membership Form

Join * Renew

Full Name: _____
Last First Middle Initial

Credentials: _____ **Date of Birth:** _____ (xx/xx/xxxx)

Home Address: _____
Street

_____ City State Zip + 4

Employer: _____ **Employer Phone** (____) _____

Work Address: _____
Street

_____ City State Zip + 4

Home Phone (____) _____ **Cell Phone** (____) _____

Primary E-mail Address _____

Secondary E-Email Address _____

Check if applicable: ____ *Do not distribute my contact information for purposes unrelated to HPNA activities.*

New Membership Renewing Membership and ID number: _____

Please PRINT clearly. * Email used for E-newsletter, membership confirmation, and organizational announcements. HPNA does not rent e-mail addresses.

Membership Level (Includes Online Subscriptions to Journal of Hospice and Palliative Nursing and Journal of Palliative Medicine)	1 Year	2 Year
RN (Voting)	<input type="checkbox"/> \$115	<input type="checkbox"/> \$210
RN Student (Full-Time Student, RN licensed, Voting)	<input type="checkbox"/> \$55	
Retired RN (RN, 70 or older, no longer working in nursing, Voting)	<input type="checkbox"/> \$45	<input type="checkbox"/> \$85
LP/VN (Non-Voting)	<input type="checkbox"/> \$82	<input type="checkbox"/> \$140
Nursing Assistant (Non-Voting)	<input type="checkbox"/> \$35	<input type="checkbox"/> \$55
Student Nurse (Full-Time Student, Non-Licensed, Non-Voting)	<input type="checkbox"/> \$45	
Associate (Non-RN; MSW, Clergy, MD, Non-Voting)	<input type="checkbox"/> \$82	
ADD Print Subscription for the Journal of Hospice and Palliative Nursing (6 issues per year)	<input type="checkbox"/> \$14	<input type="checkbox"/> \$28
Membership Total	\$	\$

Payment Information

_____ I have enclosed a check or money order in the amount of \$_____

Make checks payable to HPNA. Foreign checks cannot be accepted. Non-U.S. residents, please pay by credit card.
Mail to HPNA, One Penn Center West, Suite 425, Pittsburgh, PA 15276

_____ **Type of Credit Card:** Visa MasterCard Discover American Express

Credit Card #: _____ - _____ - _____ - _____ **Expiration Date:** (00/00) _____

Required: security number found on back of credit card _____

Print name as it appears on credit card: _____ **Cardholder Signature** _____

Billing Address: _____

City/State/Zip: _____ Billing Address Same as Home Noted Above
 Billing Address Same as Work Noted Above

_____ I am including an additional _____ as a tax-deductible gift to HPNF. *Financial gifts to the Hospice and Palliative Nurses Foundation (HPNF) are considered charitable contributions* which are used to fund nursing research, grants and awards. Please consider adding a contribution to HPNF with your payment.

Note: Payment of membership dues is not tax deductible as a charitable contribution, but may be tax deductible as ordinary and necessary business expense. HPNA estimates 5% of membership dues are allocated to lobbying activities on behalf of its members, and are therefore nondeductible as a business expense. Please consult your tax advisor for further advice.

Three Easy Ways to Join

Join online at www.gohpna.org *** Mail this application to One Penn Center West, Suite 425, Pittsburgh, PA, 15276 *** Fax this application to 412 -787-9305

Professional Experience

Professional Background:

- Nurse Practitioner Clinical Nurse Specialist RN
 LP/VN Nursing Assistant MD
 Volunteer MSW Chaplain
 Other: _____

Type of Practice:

- Clinical Educational
 Administrative Research
 Other: _____

Educational Information

- High School CNA Diploma in nursing Associate degree in nursing
 Bachelor's degree (nursing) Bachelor's degree (non-nursing) Master's degree (nursing) Master's degree (non-nursing)
 Doctoral degree (nursing) Doctoral degree (non-nursing)

Professional Demographics

Which best describes the nature of your practice?

- Hospice Care
 Palliative Care Both
 Other: _____

Total number of years in hospice/palliative care:

- 0-2yrs 3-5yrs 6-10yrs 11-15yrs
 16-20yrs 21-25yrs 26-30yrs >30yrs
 Not applicable

Total number of years in your profession:

- 0-2yrs 3-5yrs
 6-10yrs 11-15yrs
 16-20yrs 21-25yrs
 26-30yrs >30yrs
 Not applicable

Primary role (please check **ONE**):

- Staff nursing assistant Staff nurse (RN, LPN/LVN, etc.)
 Clinical supervisor/patient care coordinator
 Manager/administrator Clinical educator (including staff development)
 Advanced practitioner (i.e., CNS, NP) Faculty/researcher
 Consultant for hospice/palliative care team Other: _____

Primary employer (please check **ONE**):

- Hospice agency Home health agency
 Hospital/healthcare system Long-term facility
 College or university Self (private practice)
 Private physician practice Correctional Facility
 Ambulatory care facility Other: _____

Primary practice setting (please check **ONE**):

- Private home Nursing home, assisted living or extended care facility
 Hospital: palliative care unit Hospital: hospice unit
 Hospital: other unit or scattered beds Clinic
 Any setting in which patient resides Prison
 Freestanding residential or inpatient hospice
 I do not routinely see patients
 Other: _____

Primary age group served (please check **ONE**):

- Adult Pediatric Both

Select Your Special Interest Groups (SIGS)

HPNA SIGs approach a variety of clinical and administrative topics found within hospice and palliative care. Each community helps its members in keeping current within practice areas through timely announcements, peer connections, community web pages, and regular e-mail messages. Join as many SIGs as you like – all are included with your HPNA membership.

- Bioethics ICU Public Policy Pediatrics ER Acute Care International
 Research LPN/LVN Heart Failure Chapters Education LGBTQ Diversity
 Advanced Practice Nurse Integrative Care Community Based Palliative Care

Optional Information:

What membership benefits do you value most (select up to 3):

- Free E-Learning Courses with Contact Hours HPCC® Certification Exam Fee Discount
 Member Pricing for HPNA Products & Services Journal of Hospice and Palliative Nursing
 Journal of Palliative Medicine Advocacy
 CE-Tracking Local Chapter Involvement
 Newsletter Other: _____

Are you a member of an HPNA chapter or provisional group? Yes No

If yes, please note the name of Chapter or Group _____

How did you learn about HPNA? Journal of Hospice and Palliative Nursing Other Professional Journal
 HPNA Chapter Meeting Colleague Employer Internet Other (Please specify) _____

Gender: Female Male

Race: African American/Black Asian/Asian American/Pacific Islander Caucasian
 Hispanic Native American/Alaskan Native Multi-racial Other: _____

Thank you for your membership and support of HPNA!

Your application will be processed immediately and your membership materials will be e-mailed within one week.