



RECURRING PAYMENT AUTHORIZATION FORM

Regular or Affiliate Membership

☐ Bank transfer: I authorize APNA to charge my bank account \$12.50 each month for installment payment of my membership dues.

☐ I have enclosed a check for \$12.50 made payable to APNA for my first month's installment.

☐ Credit card: I authorize APNA to charge my credit card \$12.50 each month for installment payments of my membership dues.

☐ VISA

☐ Mastercard

☐ American Express

☐ Discover

Credit Card # _____ Exp. Date _____

Name _____

Address _____

City/State _____ Zip _____

Phone _____ Email _____

TERMS OF AGREEMENT

This authorization shall remain in effect for one year and will renew automatically unless I notify APNA in writing of my wish to cancel within 30 days of my renewal date. My monthly credit card statement or bank statement will serve as my receipt. Each year the APNA BOD reviews the annual membership fee. The fee is subject to adjust annually.

Signature _____ Date _____
(Required)

Please send completed form to:

**APNA
PO Box 75365
Baltimore, MD 21275-5365
or Fax to ,) ! , ' ! & * &**

Keep this portion for your records.

Amount authorized per month \$12.50

Date Signed _____

Please contact your Membership Department at 1 800 451-1000 or email Patti Federinko at pfederinko@apna.org with questions.

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Contact Information

FIRST NAME		LAST NAME	
CREDENTIALS			
ADDRESS			
CITY	STATE	ZIP CODE	
HOME PHONE		BUSINESS PHONE	
FAX			
E-MAIL ADDRESS (required)			
HOW DID YOU HEAR ABOUT APNA?			
VOLUNTARY APNF CONTRIBUTION* \$ _____			

APNA occasionally makes available its member addresses (excluding telephone and email) to trusted partners who provide products or services we feel will be of value to our members. Please check here if you do not wish to be included in these mailings. ☐

*Contributions or gifts to the American Psychiatric Nursing Foundation (APNF) may be deductible as charitable contributions for income tax purposes. However, dues payments to APNA are deductible for most members under section 162 of the IRS code as an ordinary and necessary business expense.

Membership Type

- ☐ Regular Member..... \$135
- ☐ Affiliate Member (Non-R.N.)... \$135
- ☐ Student Member..... \$25
Attach verification of full-time status letter from Dean of Nursing School.
- ☐ Retired Member..... \$75
- ☐ International Member..... \$135
- ☐ 2-Year Regular Member.... \$260

Total Payment \$ _____

Method of Payment

- ☐ Visa ☐ American Express
- ☐ MasterCard ☐ Check/Money Order
- ☐ Recurring – include Recurring Payment Authorization Form

AMOUNT CHARGED	
CARD NUMBER	
EXPIRATION DATE [MONTH/YEAR]	BILLING ZIP CODE
CARDHOLDER PRINTED NAME [AS IT APPEARS ON YOUR CARD]	
CARDHOLDER SIGNATURE	