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 _____

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

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

❑ New Membership ❑ Renewing Membership and ID number: _____

Membership Level (Includes Online Subscriptions to Journal of Hospice and Palliative Nursing and Journal of Palliative Medicine)	**1 Year**	**2 Year**
RN (Voting)	□ $115	□ $210
RN Student* (Full-Time Student, RN licensed, Voting)	□ $55	
Senior RN** (RNs, 70 or older, no longer working in nursing, Voting)	□ $45	□ $85
LP/VN (Non-Voting)	□ $82	□ $140
Nursing Assistant (Non-Voting)	□ $35	□ $55
Student Nurse* (Full-Time Student, Non-Licensed, Non-Voting)	□ $45	
Associate (non-RN; MSW, Clergy, MD, Non-Voting)	□ $82	
ADD Print Subscription for the Journal of Hospice and Palliative Nursing (*6 issues per year*)	□ $14	□ $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 <u>ONE</u>):

❑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 <u>ONE</u>):

❑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 <u>ONE</u>):

❑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 <u>ONE</u>):

❑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 webpages, 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 ❑ LBGTQ ❑ 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.