



www.nationalperinatal.org

Phone: 888-971-3295 Fax: 717-920-1390

# MEMBERSHIP APPLICATION

For  
Individual - Student - Retiree - Parent

## PLEASE PROVIDE COMPLETE PRIMARY CONTACT INFORMATION

First Name: _____	Title : _____
Last Name: _____	Home Phone: _____
Address : _____	Work Phone : _____
City : _____	Fax : _____
State : _____	E-mail : _____
Zip : _____	

### NPA Status (Please check the appropriate box)

- New Member       Renewing Member

### Membership Category (Please check the membership category that applies to you)

- Individual \$75       Student \$45       Retiree \$45       Parent \$45

### Journal Subscription (Please check if you wish to subscribe)

- Yes, I wish to subscribe/renew my subscription to the Journal of Perinatology at the reduced rate of \$55 (per year) with my membership.

### Profession (Please select all that apply)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Administrator             | <input type="checkbox"/> Educator                   | <input type="checkbox"/> Nurse (Other)  |
| <input type="checkbox"/> Attorney                  | <input type="checkbox"/> Therapist (Occupational)   | <input type="checkbox"/> Physician      |
| <input type="checkbox"/> Certified Nurse Midwife   | <input type="checkbox"/> Therapist (Physical)       | <input type="checkbox"/> Retired        |
| <input type="checkbox"/> Clergy                    | <input type="checkbox"/> Therapist (Rehabilitation) | <input type="checkbox"/> Social Worker  |
| <input type="checkbox"/> Clinical Nurse Specialist | <input type="checkbox"/> Therapist (Other)          | <input type="checkbox"/> Legislator     |
| <input type="checkbox"/> Consumer (Parent)         | <input type="checkbox"/> Nurse (RN)                 | <input type="checkbox"/> Other/Relative |
| <input type="checkbox"/> Consumer (Grandparent)    | <input type="checkbox"/> Nurse (BSN)                | (Please Identify)                       |
| <input type="checkbox"/> Dietitian                 | <input type="checkbox"/> Nurse (MSN)                | _____                                   |



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### Specialization (Please select all that apply)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Administration/Business | <input type="checkbox"/> Infant Development | <input type="checkbox"/> Perinatology     |
| <input type="checkbox"/> Development/Fundraising | <input type="checkbox"/> Neonatology        | <input type="checkbox"/> Public Health    |
| <input type="checkbox"/> Family Practice         | <input type="checkbox"/> Obstetrics         | <input type="checkbox"/> Other (Identify) |
| <input type="checkbox"/> Genetics                | <input type="checkbox"/> Pediatrics         |   |
- 

### Job Function (Please select all that apply)

- |   |   |                                      |
|---|---|--------------------------------------|
| <input type="checkbox"/> Administration | <input type="checkbox"/> Parenting/Grandparenting | <input type="checkbox"/> Research    |
| <input type="checkbox"/> Consultation   | <input type="checkbox"/> Patient Care             | <input type="checkbox"/> Supervision |
| <input type="checkbox"/> Education      | <input type="checkbox"/> Public Health            | <input type="checkbox"/> Other       |
- 

### Payment Method (If paying by credit card)

- Visa  
 MasterCard

### Credit Card Information

Card Number	:	_____
Expiration Number:		_____
Name on card	:	_____
Total Charged	:\$	_____
Signature	:	_____

### Payment Method (If paying by check)

- Check    Check Amount: \$

Send Membership Application with payment to:

**National Perinatal Association  
2090 Linglestown Rd., Suite 107  
Harrisburg, PA 17110**