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

**MEMBERSHIP  
APPLICATION**  
For State Perinatal Associations

**PLEASE PROVIDE SPA INFORMATION**

Name	:	_____
Address	:	_____
City	:	_____
State	:	_____
Zip	:	_____
Website	:	_____
Non-Profit Status:		_____
Year Established :		

**EXECUTIVE DIRECTOR OR PRESIDENT CONTACT INFORMATION**

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



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**PLEASE PROVIDE SECONDARY/OTHER OFFICER CONTACT**

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

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

- New Member       Renewing Member

**SPA Membership** (Please provide details)

Current Membership?	_____
Membership Growth Past 5 years?	<input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> Stable
Annual Membership Dues?	\$ _____
Membership Conferences?	<input type="checkbox"/> Annual <input type="checkbox"/> None <input type="checkbox"/> Biannual <input type="checkbox"/> Other _____
Date/Site of Education conference?	_____



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**Board Structure** (Please provide details)

Number of Board members?	_____	
Compensation?	<input type="checkbox"/> Volunteer	
	<input type="checkbox"/> Paid Positions	
Current Executive Director?	<input type="checkbox"/> Yes	
	<input type="checkbox"/> No	
Professionals? (all that apply)	<input type="checkbox"/> RN	<input type="checkbox"/> Non-medical
	<input type="checkbox"/> MD	<input type="checkbox"/> Parent
	<input type="checkbox"/> RD	<input type="checkbox"/> Other _____
	<input type="checkbox"/> IBCLC	
Board Member Affiliations?	<input type="checkbox"/> AAP	<input type="checkbox"/> NAPNAP
	<input type="checkbox"/> AAFP	<input type="checkbox"/> NPA
	<input type="checkbox"/> ACOG	<input type="checkbox"/> Other _____
	<input type="checkbox"/> AWHONN	
Board meeting frequency?	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Annual
	<input type="checkbox"/> Semi-annually	<input type="checkbox"/> Other _____
Active in State Legislative Efforts?	<input type="checkbox"/> Yes	
	<input type="checkbox"/> No	
Problems recruiting new board members?	<input type="checkbox"/> Yes	
	<input type="checkbox"/> No	

**Membership Category**

- State Perinatal Association \$200

**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.

**Payment Method** (If paying by Credit Card)

- Visa  
 MasterCard



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**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**

**Comment Section** (Please provide comments)

Recent Projects/Successes \_\_\_\_\_

Recent Challenges/Problems \_\_\_\_\_

Other Comments \_\_\_\_\_

Suggestions For NPA \_\_\_\_\_