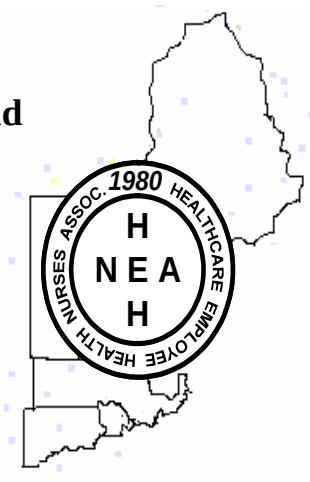
HEHNA MEMBERSHIP APPLICATION

Healthcare Employee Health Nurses Association of New England

for RENEWAL and NEW MEMBERS

YEAR _____



***NOTE**: This form is **fill-able**; type in your information, then print it for mailing*

Renewal: ◯ New Member: ◯

NAME: _____

TITLE: _____

WORK

FACILITY name: _____

DEPARTMENT: _____

STREET Address: _____

CITY: _____

STATE & ZIP CODE: _____

OFFICE PHONE Number: _____-_____-_____

OFFICE FAX Number: _____-_____-_____

WORK E-MAIL Address: _____

TITLE of Person Directly Responsible to: _____

Number of YEARS Worked in Employee/ Occ Health: _____

Nursing Designation: ☐ **NP/APRN**(or ARNP) ☐ **RN** ☐ **LPN**

Certifications/ Special Interests: ☐ **FNP-BC** ☐ **ANP-BC** ☐ **COHN** ☐ **COHN-S** ☐ **CCM** ☐ **CIC**

☐ **HRM** ☐ **CEAS I** ☐ **CEAS II** ☐ **CEAS III** ☐ **Other:** _____

HOME

STREET Address: _____

CITY: _____

STATE & ZIP CODE: _____

HOME Phone Number: _____-_____-_____

CELL Phone Number: _____-_____-_____

HOME E-MAIL Address: _____

PLEASE DO ***NOT*** SEPARATE – MAIL THE ***WHOLE*** FORM!

ANNUAL DUES: $50 *Renewals DUE by:* MAY 1st

Please **make checks *payable to***:

Healthcare Employee Health Nurses Association *or* HEHNA

MAIL Check and completed Application Form to:

Janice Parker, HEHNA Treasurer
Employee Health Services
Frisbie Memorial Hospital
11 Whitehall Road
Rochester, NH 03867

FOR TREASURER'S USE: Date Check Received _____