International Society of Psychiatric-Mental Health Nurses

2424 American Lane • Madison, WI 53704-3102 USA • Phone: 1-608-443-2463 • Fax: 1-608-443-2474
Email: info@ispn-psych.org • Website: www.ispn-psych.org

ISPN Membership Application

Please complete the following information and mail, fax or email (no purchase orders) to:
Mail: ISPN Membership, 2424 American Lane, Madison, WI 53704, USA
Fax: +1-608-443-2474 or +1-608-443-2478
Email: info@ispn-psych.org

Name: _____
First Middle Last Credentials

Title: _____

Affiliation: _____

Affiliation Address: _____

_____
City State/Province Zip/Postal Code Country *(if other than USA)*

Home Address: _____

_____
City State/Province Zip/Postal Code Country *(if other than USA)*

Preferred Mailing Address: ❒ Affiliation ❒ Home

Home Phone: _____ Daytime Phone: _____ Email: _____

The following line of questions are optional and for demographic analysis only:

Gender: ❒ Female ❒ Male Race/Ethnicity_____ Highest Degree _____ Years in Practice _____

Student: ❒ Yes* ❒ No *Students must provide verification of student status (copy of ID, class schedule, etc.).

Referring Member (optional): _____

Are you an ANA member? ❒ Yes ❒ No If YES, ANA membership number: _____

Do you have prescriptive authority in your state? ❒ Yes ❒ No

ANCC certification as: ❒ Adult PMHNP ❒ Family PMHNP ❒ Adult PMHCNS ❒ Child PMHCNS

My Research Interest is: _____

My Clinical Interest is: _____

My Population Focus is: _____

I currently act as an ISPN liaison to these professional groups or organizations (optional): _____

How did you hear about ISPN? _____

I am interested in participating in the following committees: (optional)

- ❒ Awards Committee
- ❒ Communications Committee
- ❒ Conference Committees
- ❒ Diversity & Equity Committee
- ❒ Finance Committee
- ❒ Marketing and Development Committee
- ❒ Membership Committee
- ❒ Nominating Committee
- ❒ Website Management Committee

Over, please

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Member Rates

Full Member	❒ $150
Student Member*	❒ $25
Retired Member	❒ $60

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Charitable Donation

If you are interested in making a donation to the ISPN Foundation, select any Donation Type and any Amount:

Donation Type:	**Amount:**
❒ Lamplighter ($100 for 5 years = $500 total)	
❒ General Contribution	❒ $1,000
❒ Mental Health and Wellness Research Scholarship	❒ $500
❒ Hertha Gast Scholarship	❒ $300
❒ Carol Williams Memorial Scholarship Fund	❒ $200
❒ Susan McCabe Lecture Fund	❒ $100
❒ Greatest Need	❒ $50
❒ Sustained Giving (Annual donation)	❒ $25
❒ None	❒ Other Amount: $_____

Periodically corporations, institutions, and healthcare recruitment agencies ask ISPN to provide the ISPN membership for mailings. Please check here if you do not wish your name and address to be included:

❒ Please do not release my name and address to corporations, institutions, or agencies outside of ISPN.

May ISPN send you Society updates, such as conference abstract submission opening and closing dates; Award and Officer nomination, election results; and conference information (hotels, registration, program/schedule updates, etc.)?

❒ **Yes, I would like to OPT IN**

Fees Due

Membership Fee	$_____
Charitable Donation	$_____
Total Amount Due	**$**_____

Payment Options

❒ Check (payable to ISPN; US Funds only)

❒ MasterCard/Visa/Discover

CC# _____ Expiration Date: _____

Name on Card: _____

Signature: _____