# Indiana League for Nursing Membership Form

**Name:** _____ **Credentials:** _____

**Address:** _____

**City:** _____

**State:** _____

**Zip Code:** _____

**Work:** _____

**Home:** _____

**Cell:** _____

*Please ** preferred contact phone*

**Email:** _____

**Employer:** _____ **Title:** _____

**Please check your primary service areas of interest below:**

- ☐ Finance
- ☐ Global Health
- ☐ Legislative
- ☐ Membership
- ☐ Nominations
- ☐ Programming
- ☐ Public Relations
- ☐ Scholarship & Awards
- ☐ Strategic Planning

**Please check your level of membership:**

| | |
|---|---|
| ☐ 1-Year Regular Membership | $45 |
| ☐ 2-Year Regular Membership | $80 |
| ☐ 1-Year Student Membership (ID Required) | $25 |
| ☐ 1-Year Retired Membership | $25 |

*Please enclose a check or money order to the **Indiana League for Nursing** along with this completed form to:*

*Brian A. Arwood, Treasurer*
*Indiana League for Nursing*
*173 E 5th St*
*Peru, IN 46970*