TEXAS NURSE PRACTITIONERS

2011 MEMBERSHIP FORM

Full Name _____ Email _____

Title _____ Preferred Address _____

TNP ID Number (If Renewal) _____ City _____ State _____ Zip _____

County _____ Home Phone _____ Work Phone _____

Professional Information:

Are you recognized as an APN by the Texas BON? ___ yes ___ no

If yes, what specialty are you recognized as by the BON?

___ Community/Public Health
___ General Practice
___ Geriatrics
___ Obstetrics/Gynecology
___ Medical/Surgical
___ Pediatrics
___ Psychiatric/Mental Health/ Substance Abuse
___ Anesthesia
___ Emergency Care
___ Home Health
___ Intensive/Critical Care
___ Neonatology
___ Oncology
___ Operating/Recovery Care
___ Rehabilitation
___ Occupational/Environmental Health

Other: _____

Clinical Focus: What is your current clinical focus? *(Choose all that apply)*

___ Adult
___ Acute Care
___ Cardiology
___ College Health
___ Correctional
___ Dermatology
___ Emergency
___ Endocrinology
___ Faculty (NP Program)
___ Faculty (BSN Program)
___ Faculty (Medical School)
___ Family
___ Family Planning
___ Gastroentology
___ Gerontologic
___ Internal Medicine
___ Neonatal
___ Neurology
___ Oncology
___ Ophthalmology
___ Orthopedic
___ Palliative Care
___ Pediatric
___ Psychiatric
___ School
___ Surgery
___ Urology
___ Women's Health

Other: _____

Practice Settings: *(Choose all that apply)*

___ College Health Clinic
___ Convenient Care/Retail Clinic
___ Correctional/ Prison Facility
___ Emergency Room/Urgent Care Clinic
___ Employee/Occupational Health
___ HMO
___ Home Health Care
___ Hospice
___ Hospital Owned Outpatient Clinic
___ In-Patient Hospital
___ Long Term Care Facility
___ Management/Administration
___ Military
___ NP Program Faculty
___ Private NP Practice
___ Private Physician Practice
___ Public Health NP
___ Retail Clinic
___ School Health Clinic
___ VA Facility

Other: _____

Preceptor List: I would like to be on the TNP Preceptor List: ___ yes ___ no

Forum: I would like to join the TNP Mental Health/Psychiatric Forum: ___ yes ___ no

Undergraduate Educ.: Degree: _____ Institution: _____

Graduate Education: Degree: _____ Institution: _____

Certification Reminders: *(provide date for each)*

RN License Renewal: ___/___/___
NP Certification Renewal: ___/___/___
DPS Number Renewal: ___/___/___
DEA Renewal: ___/___/___
Liability Insurance Renewal: ___/___/___
Credentialing to Hospitals Renewal: ___/___/___
BLS Renewal: ___/___/___
ACLS Renewal: ___/___/___
PALS Renewal: ___/___/___

Corporate/Community Board Involvement: ; _____ ; _____ ; _____ ; _____ ; _____

Membership Categories:

☐ Regular Membership Fee $115
☐ Student Membership Fee $55

*(*Students are required to provide proof of student status.)*

☐ Retired Membership Fee $75
☐ Associate Membership Fee $100
☐ New ☐ Renewal

If new, how did you hear about TNP?

_____

☐ TNPF Donation $_____
☐ Legislative Donation $_____
☐ Education Donation $_____

(Membership dues to TNP are not deductible as charitable contributions but may be deductible as a business expense for Federal Income tax purposes.)

Payment Method:

☐ Enclosed is my check payable to: *Texas Nurse Practitioners*

Please charge to: ☐ Visa ☐ Mastercard

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Card Security Code *(last 3 digits from back of card)* Exp. Date

Billing Address

City State Zip

Signature

Please mail this form with payment to:
Texas Nurse Practitioners | 4425 S. Mopac
Building III, Suite 405 | Austin, Texas 78735

Or fax if paying by credit card to: 512.291.6225

Questions? Call 512.291.6224 or
Email: admin@texasnp.org or Visit www.texasnp.org