



CALIFORNIA ASSOCIATION
FOR NURSE PRACTITIONERS

Membership Application

Annual Membership

PLEASE PRINT CLEARLY

NAME _____ CREDENTIAL _____

PREFERRED E-MAIL (*used only by CANP for CANP updates*) _____

Please complete both addresses and then mark your mailing address preference:

☐ HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____ HOME TELEPHONE (_____) _____

☐ BUSINESS NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ BUSINESS TELEPHONE (_____) _____

REFERRED BY _____ CA RN LICENSE # _____ Date of Birth (month/date) _____

CANP Membership Categories – Chapter dues are included in state dues

NP FULL

☐ **\$250**

NP Full Membership is extended to those NPs licensed to practice and reside in California. This member shall have full and exclusive voting privileges and rights to hold office.

FIRST YEAR GRADUATE

☐ **\$175**

First Year Graduate Membership individuals must provide diploma or transcript showing graduation date occurred within the last year prior to joining to qualify for this discounted rate and is good for one year only. This member shall have full and exclusive voting privileges and renewal will be at Full Membership rate.

ASSOCIATE

☐ **\$160**

Associate Membership is extended to those individuals who are retired NPs, out-of-state NPs or those interested in and/or associated with the profession, but who are not included in any other classification of membership. This member shall not have the right to vote or hold office.

SENIOR

☐ **\$160**

Senior Membership is extended to NPs holding an active RN license and who are 65 and older and older and residing in California. This member shall have full and exclusive voting privileges and the right to hold office.

STUDENT

☐ **\$125**

NP Student Membership is extended to students enrolled (full or part time) in an accredited NP program and to those who renew their student membership, limited to two years. School and graduation date must be provided. This member shall not have the right to vote or hold office, but may sit on committees. **REQUIRED INFORMATION FOR STUDENT MEMBERSHIP:**

SCHOOL _____ GRADUATION DATE _____

Payment

CANP Political Action Committee PAC ID # 860692 \$ _____

Dues \$ _____

Total \$ _____

Please consider making a contribution of \$25, \$50, \$100 or any amount you can contribute to the CANP PAC Fund. Your contribution will help ensure Nurse Practitioners have a strong voice in our State Capitol.

Payment Options:

☐ Check # _____ enclosed (**Checks payable to CANP**) ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Card Number _____ V-Code _____ Expiration Date _____

Name on Card _____ Signature _____

Your check or money order is your receipt. Pursuant to Federal Law, we must notify you that 25% of your dues are for lobbying expenses and are not tax deductible. The remainders of CANP dues are not tax deductible as a charitable contribution for Federal Tax purposes, but may be deductible as a business expense. All contributions and gifts to the CANP PAC are considered political contributions and are not tax deductible.



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PLEASE INDICATE YOUR PRIMARY SPECIALTY – (Adult, Cardiology, Pediatrics, Women’s Health, etc.)

CANP Special Interest Groups (SIGs)

I am interested in joining a Special Interest Group

☐ Geriatrics ☐ Acute Care ☐ NP Entrepreneurs ☐ Cardiology ☐ Orthopedics ☐ Psychiatry ☐ Homeless Health ☐ Women’s Health

If you are interested in forming an additional SIG, please contact CANP Membership Services Mgr, Erin Meyer at erin@canpweb.org

CANP Committees

I am interested in serving on one of these committees when the opportunity is available:

☐ Membership

☐ Educational Affairs

☐ Public Relations

CANP Resource

☐ I am interested in being a resource when an expert is needed for media, legislative purposes, etc. My area of expertise is:

CANP Member Communications

☐ I do not wish to appear on the consumer searchable database.

☐ I do not wish to receive fax or email correspondence from CANP.

☐ Please remove me from outside (organizations not endorsed by CANP) mailing list requests.

CANP Membership Agreement

Upon submission of this application, I hereby agree to act in accordance with the laws, rules, and regulations of the state of California, the federal government, and in accordance with the Code of Ethics, Standards of Practice, and bylaws of the California Association for Nurse Practitioners. Failure to do so may result in the termination of my membership without refund. Once accepted into membership, dues are non-refundable. I understand that I will receive correspondence via fax/phone/e-mail sent by or on behalf of the California Association for Nurse Practitioners (CANP).

SIGNATURE _____

DATE _____