AANP | American Association of NURSE PRACTITIONERS®

If filling out this form electronically, please complete, print and mail to: AANP, P.O. Box 12846, Austin, TX 78711 or fax to 512-442-6469.

2019 AANP FALL CONFERENCE REGISTRATION & MEMBERSHIP APPLICATION

The information below is needed for both conference registrants and membership applicants.

☐ New Member ☐ Renewal

Member # (if previously a member):_____

Name:

_____
First Middle Last

Preferred Mailing Address: ☐ Home ☐ Work

_____
Company Name (if work address)

_____
Street

_____
City State Zip Code

Home Phone:_____

Work Phone: _____ Ext.

Cell Phone:_____

Email: _____

AANP policy allows the release of a member's mailing address for educational, research and recruitment purposes only.

☐ Check box if you do not want your mailing address released.

Phone and email information is for internal use only by AANP staff, elected officials, state representatives and AANP vendors for fulfilling member services.

DEMOGRAPHIC INFORMATION

(Utilizing federal classifications for ethnicity and race, check all that apply.)

Gender: ☐ Female ☐ Male **Year of Birth:** 19 __ __

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White

MILITARY INFORMATION

Have you ever served on active duty in the U.S. Armed Forces, Reserves or National Guard?

☐ Never served in the military ☐ Only on active duty for training in the Reserves or National Guard

EDUCATIONAL INFORMATION

Highest Level of Education: (Please select ONE.)

☐ Certificate
☐ Nursing Associate
☐ Non-nursing Associate
☐ Nursing Bachelor's
☐ Non-nursing Bachelor's
☐ Nursing Master's
☐ Non-nursing Master's
☐ Doctor of Nursing Practice
☐ Nursing PhD
☐ Other Nursing Doctorate
☐ Non-nursing Doctorate

Year of NP Program Completion: (If you hold degrees from multiple NP programs, enter the year that you completed your initial program.)

__ __ __ __

STUDENT MEMBERSHIP INFORMATION

☐ Student ☐ Post Master's Student

Name of School:_____

City: _____State:_____ Program Specialty: _____

Anticipated Year of NP Program Completion: __ __ __ __

If the applicant is a student in an entry-level NP program, skip the Professional Information section and go to the Membership Payment Information section below.

PROFESSIONAL INFORMATION

NATIONAL PROVIDER IDENTIFIER (NPI)#_____

ARE YOU WORKING OR VOLUNTEERING AS AN NP? ☐ Yes

☐ No, I am an NP, but I am not currently working
☐ No, I am a retired NP
☐ No, I am an NP student
☐ No, I am another APRN (CNS, CNM, CRNA)
☐ No, I am another type of nurse
☐ No, I am not an NP or a nurse

ARE YOU LICENSED AS AN NP? ☐ Yes ☐ No

ARE YOU CERTIFIED AS AN NP? ☐ Yes ☐ No

NP CERTIFICATION(S): (Please check all that apply.)

☐ Acute Care
☐ Addiction Registered Nurse — Advanced Practice
☐ Adult
☐ Adult-Gerontology-Acute Care
☐ Adult-Gerontology-Primary Care
☐ Dermatology
☐ Diabetes Management — Advanced
☐ Emergency
☐ Family
☐ Gerontology
☐ Hospice and Palliative Care
☐ Neonatal
☐ Oncology
☐ Orthopedics
☐ Pediatrics — Acute Care
☐ Pediatrics — Primary Care
☐ Pediatrics — Primary Care Mental Health
☐ Psychiatric/Mental Health
☐ Psychiatric/Mental Health — Adult
☐ Psychiatric/Mental Health — Family
☐ School Health
☐ Women's Health
☐ None
☐ Other, please specify: _____

NP WORK SETTING:
(Please select ONE setting, preferably your main work site.)

☐ Assisted Living
☐ College Health
☐ Community Health Center
☐ Correctional / Prison Facility
☐ Emergency Room
☐ Family Planning Clinic
☐ Federally Qualified Health Center
☐ Government Agency
☐ Health Department
☐ HMO
☐ Home Health Care
☐ Hospice / Palliative Care
☐ Hospital Inpatient Clinic
☐ Hospital Outpatient Clinic
☐ Indian Health Service
☐ Insurance Company, private
☐ Insurance Company, public
☐ Long-term Care Facility
☐ Migrant Health Clinic
☐ Military / DoD
☐ Occupational Health Clinic
☐ Private Group Practice
☐ Private NP Practice
☐ Private Physician Practice
☐ Psych / Mental Health Facility
☐ Public Housing Primary Care
☐ School Health Clinic
☐ Rehabilitation Facility
☐ Retail Clinic
☐ Rural Health Clinic
☐ University, private
☐ University, public
☐ Urgent Care
☐ VA Facility
☐ Other, please specify: _____

YOUR CLINICAL FOCUS AT YOUR MAIN NP WORK SITE:
(Please select ONE clinical focus.)

☐ Administration
☐ Cardiology
☐ Complementary/Alternative
☐ Dermatology
☐ Emergency
☐ Endocrinology
☐ End-of-life Care
☐ ENT
☐ Faculty
☐ Gastroenterology
☐ Genetics
☐ Health Promotion
☐ Hematology
☐ Immunology / Rheumatology
☐ Neurology
☐ OB/GYN
☐ Occupational
☐ Oncology
☐ Orthopedics
☐ Pain Medicine
☐ Primary Care
☐ Psychiatric
☐ Research
☐ Respiratory
☐ Surgical
☐ Urgent Care
☐ Urology / Nephrology
☐ Wound Care
☐ None
☐ Other, please specify: _____

MEMBERSHIP DUES INFORMATION

MEMBERSHIP TYPE: ☐ Student $55 ☐ Post Master's Student $95 ☐ Career Starter $95 ☐ NP $135 ☐ Associate $145 ☐ Retired $55

For additional membership information and to join or renew your membership, visit aanp.org. Memberships are nonrefundable.

CONFERENCE SESSIONS

PLEASE PRINT LEGIBLY

Name: _____
First Middle Last

Please write in the **entire session number** for your preferred selections. Where applicable, indicate your first, second and third choices. No selection is guaranteed. If no selections are provided, your registration cannot be processed.

Please note: During a given time frame, you can register to attend **only one** session.
If you register for a workshop, you will not be able to attend concurrent presentations occuring during the same time frame.

THURSDAY, OCTOBER 10		1ST CHOICE	2ND CHOICE	3RD CHOICE
8:00 a.m. – 9:00 a.m.	CONCURRENT PRESENTATION			
8:00 a.m. – 11:00 a.m.	WORKSHOP			
9:15 a.m. – 10:15 a.m.	CONCURRENT PRESENTATION			
1:15 p.m. – 2:15 p.m.	CONCURRENT PRESENTATION			
1:15 p.m. – 4:15 p.m.	WORKSHOP			
2:30 p.m. – 3:30 p.m.	CONCURRENT PRESENTATION			
FRIDAY, OCTOBER 11		**1ST CHOICE**	**2ND CHOICE**	**3RD CHOICE**
8:00 a.m. – 9:00 a.m.	CONCURRENT PRESENTATION			
8:00 a.m. – 11:00 a.m.	WORKSHOP			
9:15 a.m. – 10:15 a.m.	CONCURRENT PRESENTATION			
10:30 a.m. – 11:30 a.m.	CONCURRENT PRESENTATION			
1:30 p.m. – 2:30 p.m.	CONCURRENT PRESENTATION			
1:30 p.m. – 4:30 p.m.	WORKSHOP			
2:45 p.m. – 3:45 p.m.	CONCURRENT PRESENTATION			
SATURDAY, OCTOBER 12	**DESCRIPTION**	**1ST CHOICE**	**2ND CHOICE**	**3RD CHOICE**
7:30 a.m. – 12:00 p.m.	WORKSHOP			
8:00 a.m. – 9:00 a.m.	CONCURRENT PRESENTATION			
8:45 a.m. – 9:45 a.m.	CONCURRENT PRESENTATION			
10:00 a.m. – 11:00 a.m.	CONCURRENT PRESENTATION			
11:15 a.m. – 12:15 p.m.	CONCURRENT PRESENTATION			
1:00 p.m. – 4:30 p.m.	WORKSHOP			
2:00 p.m. – 3:00 p.m.	CONCURRENT PRESENTATION			
3:15 p.m. – 4:15 p.m.	CONCURRENT PRESENTATION			
SUNDAY, OCTOBER 13		**1ST CHOICE**	**2ND CHOICE**	**3RD CHOICE**
7:30 a.m. – 8:30 a.m.	CONCURRENT PRESENTATION			
8:00 a.m. – 10:30 a.m.	SEMINAR			
8:45 a.m. – 9:45 a.m.	CONCURRENT PRESENTATION			
10:00 a.m. – 11:00 a.m.	CONCURRENT PRESENTATION			

For current selection of sessions, register online at **aanp.org/fall19.**

CONFERENCE FEES

PLEASE PRINT LEGIBLY

Name: _____
First Middle Last

By submitting this registration, the registrant acknowledges he or she has read and agrees to the Terms of Service and Release of Liability published online at release.aanp.org.

October 10–13 Registration Fees

(Please ✔ Registration Category)

☐ NP Member	$495
☐ Associate Member	$495
☐ Student Member	$375
☐ Post Master's Student Member	$375
☐ Career Starter Member	$375
☐ Retired Member	$375
☐ Non-AANP Member	$645

If on-site registration is available, fees will increase by $50 in all categories.

Subtotal Registration Fee:

Workshops

☐ F19.1.012 Advanced Suturing & Digital Blocks	$125
☐ F19.1.042 Punch and Shave Biopsies	$125
☐ F19.2.012 Urgent Care Procedure Skills	$125
☐ F19.2.042 Advanced Neurologic Exam: Beyond the Cranial Nerves	$125
☐ F19.3.005 Critical Care Ultrasound	$125
☐ F19.3.030 Introduction to Bedside Ultrasound	$125

Subtotal Workshop Fee:

AANP Membership Fees

☐ NP	$135
☐ Student	$55
☐ Post Master's Student	$95
☐ Career Starter	$95
☐ Retired	$55
☐ Associate	$145

Subtotal Membership Fee:

Payment Information

To register for conference, please remember to fax or mail pages 1R– 3R. Payment must be included with the form. Thank you!

Grand Total:

Forward registration form and payment to: AMERICAN ASSOCIATION OF NURSE PRACTITIONERS • P.O. BOX 12846 • AUSTIN, TX 78711
If paying by credit card, you may fax to AANP at 512-442-6469.

☐ Enclosed is my check payable to: American Association of Nurse Practitioners ☐ Please charge to my credit card: ☐ Visa ☐ MasterCard ☐ American Express

Card Number: _____ Expiration Date: _____ Billing Zip Code: _____ Security Code: _____

Cardholder Name: _____ Signature: _____

Please Print