



Institutional/Corporate Membership Application

www.snrs.org | info@snrs.org

Please Print Clearly:

Institution/Corporation: _____

Primary Contact Name: _____ Primary Contact Email: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Office Phone: _____ Fax Number: _____

Institution/Corporation Email: _____

Membership Dues: *Select only one Membership Category - see descriptions below.*

- Corporate Member** – Commercial entities with an interest in promoting or supporting nursing research within the region. One representative will receive Associate Member status, recognition on the SNRS website, two members will receive reduced prices for the Annual Conference, discount on exhibitor space, and inclusion in online searchable Membership Directory. **Dues \$250.00**
- Institutional Member** – Colleges, universities or health care entities within the region that are interested in promoting nursing research. Five representatives will receive reduced prices for the Annual Conference, recognition on the SNRS website, and inclusion in online searchable Membership Directory. **Dues \$650.00**

(Please provide names of members on following pages)

MEMBERSHIP SUBTOTAL: _____

SNRS Grant and Awards Contributions: Your tax deductible contribution will ensure that the SNRS awards and grants programs will continue

- \$25 \$50 \$75 \$100 \$_____

CONTRIBUTION SUBTOTAL: _____

Payment Information:

- CHECK MONEY ORDER VISA MASTERCARD AMERICAN EXPRESS DISCOVER

Card Number: _____ Exp. Date: _____

Name on Card: _____ CVV Code: _____

Signature: _____

Please make check or money order payable to: SNRS | PO Box 723248, Atlanta, GA 31139, USA

Credit Card Payments can be faxed to SNRS at 913-222-8606.

You may also renew online at www.snrs.org

MEMBERSHIP DUES: \$ _____

OTHER: \$ _____

TOTAL INCLUDED: \$ _____



Institutional/Corporate Membership Application

www.snrs.org | info@snrs.org

Institutional Members:

Name: DR. MRS. MR. MS. _____

Title: _____ Credentials: _____

Affiliation: _____

Preferred Mailing Address: HOME BUSINESS

Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Home Phone: _____ Office Phone: _____

Fax Number: _____ E-mail: _____

Gender: MALE FEMALE Ethnicity: CAUCASIAN HISPANIC ASIAN AFRICAN AMERICAN OTHER

Please check the box to indicate your current research career level:

DOCTORAL EARLY CAREER MID-CAREER SENIOR SCIENTIST OTHER _____

STUDENT (GRADUATE) STUDENT (UNDERGRADUATE) ANTICIPATED GRADUATION DATE: _____

Please check the box that best describes your current employer: ACADEMIC INSTITUTION CLINICAL AGENCY

Research Interest Groups: *Two RIG affiliations are INCLUDED in your dues; additional affiliations are \$15.00 ea.*

- | | | |
|---|--|--|
| <input type="checkbox"/> Aging/Gerontology | <input type="checkbox"/> Minority Health Research | <input type="checkbox"/> Qualitative |
| <input type="checkbox"/> Biobehavioral | <input type="checkbox"/> Parent-Child | <input type="checkbox"/> Research in Clinical Settings |
| <input type="checkbox"/> Education | <input type="checkbox"/> Psychiatric/Mental Health | <input type="checkbox"/> Health Systems/Health Policy |
| <input type="checkbox"/> Community Public Health/Health Promotion | | |

RIG SUBTOTAL: _____

Name: DR. MRS. MR. MS. _____

Title: _____ Credentials: _____

Affiliation: _____

Preferred Mailing Address: HOME BUSINESS

Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Home Phone: _____ Office Phone: _____

Fax Number: _____ E-mail: _____

Gender: MALE FEMALE Ethnicity: CAUCASIAN HISPANIC ASIAN AFRICAN AMERICAN OTHER

Please check the box to indicate your current research career level:

DOCTORAL EARLY CAREER MID-CAREER SENIOR SCIENTIST OTHER _____

STUDENT (GRADUATE) STUDENT (UNDERGRADUATE) ANTICIPATED GRADUATION DATE: _____

Please check the box that best describes your current employer: ACADEMIC INSTITUTION CLINICAL AGENCY

Research Interest Groups: *Two RIG affiliations are INCLUDED in your dues; additional affiliations are \$15.00 ea.*

- | | | |
|---|--|--|
| <input type="checkbox"/> Aging/Gerontology | <input type="checkbox"/> Minority Health Research | <input type="checkbox"/> Qualitative |
| <input type="checkbox"/> Biobehavioral | <input type="checkbox"/> Parent-Child | <input type="checkbox"/> Research in Clinical Settings |
| <input type="checkbox"/> Education | <input type="checkbox"/> Psychiatric/Mental Health | <input type="checkbox"/> Health Systems/Health Policy |
| <input type="checkbox"/> Community Public Health/Health Promotion | | |

RIG SUBTOTAL: _____



Institutional/Corporate Membership Application

www.snrs.org | info@snrs.org

Institutional Members:

Name: DR. MRS. MR. MS. _____

Title: _____ Credentials: _____

Affiliation: _____

Preferred Mailing Address: HOME BUSINESS

Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Home Phone: _____ Office Phone: _____

Fax Number: _____ E-mail: _____

Gender: MALE FEMALE Ethnicity: CAUCASIAN HISPANIC ASIAN AFRICAN AMERICAN OTHER

Please check the box to indicate your current research career level:

DOCTORAL EARLY CAREER MID-CAREER SENIOR SCIENTIST OTHER _____

STUDENT (GRADUATE) STUDENT (UNDERGRADUATE) ANTICIPATED GRADUATION DATE: _____

Please check the box that best describes your current employer: ACADEMIC INSTITUTION CLINICAL AGENCY

Research Interest Groups: *Two RIG affiliations are INCLUDED in your dues; additional affiliations are \$15.00 ea.*

- | | | |
|---|--|--|
| <input type="checkbox"/> Aging/Gerontology | <input type="checkbox"/> Minority Health Research | <input type="checkbox"/> Qualitative |
| <input type="checkbox"/> Biobehavioral | <input type="checkbox"/> Parent-Child | <input type="checkbox"/> Research in Clinical Settings |
| <input type="checkbox"/> Education | <input type="checkbox"/> Psychiatric/Mental Health | <input type="checkbox"/> Health Systems/Health Policy |
| <input type="checkbox"/> Community Public Health/Health Promotion | | |

RIG SUBTOTAL: _____

Name: DR. MRS. MR. MS. _____

Title: _____ Credentials: _____

Affiliation: _____

Preferred Mailing Address: HOME BUSINESS

Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Home Phone: _____ Office Phone: _____

Fax Number: _____ E-mail: _____

Gender: MALE FEMALE Ethnicity: CAUCASIAN HISPANIC ASIAN AFRICAN AMERICAN OTHER

Please check the box to indicate your current research career level:

DOCTORAL EARLY CAREER MID-CAREER SENIOR SCIENTIST OTHER _____

STUDENT (GRADUATE) STUDENT (UNDERGRADUATE) ANTICIPATED GRADUATION DATE: _____

Please check the box that best describes your current employer: ACADEMIC INSTITUTION CLINICAL AGENCY

Research Interest Groups: *Two RIG affiliations are INCLUDED in your dues; additional affiliations are \$15.00 ea.*

- | | | |
|---|--|--|
| <input type="checkbox"/> Aging/Gerontology | <input type="checkbox"/> Minority Health Research | <input type="checkbox"/> Qualitative |
| <input type="checkbox"/> Biobehavioral | <input type="checkbox"/> Parent-Child | <input type="checkbox"/> Research in Clinical Settings |
| <input type="checkbox"/> Education | <input type="checkbox"/> Psychiatric/Mental Health | <input type="checkbox"/> Health Systems/Health Policy |
| <input type="checkbox"/> Community Public Health/Health Promotion | | |

RIG SUBTOTAL: _____



Institutional/Corporate Membership Application

www.snrs.org | info@snrs.org

Institutional Members:

Name: DR. MRS. MR. MS. _____

Title: _____ Credentials: _____

Affiliation: _____

Preferred Mailing Address: HOME BUSINESS

Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Home Phone: _____ Office Phone: _____

Fax Number: _____ E-mail: _____

Gender: MALE FEMALE Ethnicity: CAUCASIAN HISPANIC ASIAN AFRICAN AMERICAN OTHER

Please check the box to indicate your current research career level:

DOCTORAL EARLY CAREER MID-CAREER SENIOR SCIENTIST OTHER _____

STUDENT (GRADUATE) STUDENT (UNDERGRADUATE) ANTICIPATED GRADUATION DATE: _____

Please check the box that best describes your current employer: ACADEMIC INSTITUTION CLINICAL AGENCY

Research Interest Groups: *Two RIG affiliations are INCLUDED in your dues; additional affiliations are \$15.00 ea.*

- | | | |
|---|--|--|
| <input type="checkbox"/> Aging/Gerontology | <input type="checkbox"/> Minority Health Research | <input type="checkbox"/> Qualitative |
| <input type="checkbox"/> Biobehavioral | <input type="checkbox"/> Parent-Child | <input type="checkbox"/> Research in Clinical Settings |
| <input type="checkbox"/> Education | <input type="checkbox"/> Psychiatric/Mental Health | <input type="checkbox"/> Health Systems/Health Policy |
| <input type="checkbox"/> Community Public Health/Health Promotion | | |

RIG SUBTOTAL: _____