National Student Nurses' Association

JOIN US ONLINE!
www.nsnamembership.org

2025–2026 MEMBERSHIP APPLICATION

Please complete all information. May be photocopied for distribution.
Do not staple or tape payment to application.

Applicant's Certification: I am eligible for and am applying for NSNA membership. I am currently enrolled in Nursing School or a pre-nursing program. I authorize NSNA to request documentation from the nursing registrar and nursing program to verify my enrollment status. I certify that all statements made in this application are complete and accurate. I understand that falsifications in my application will disqualify my application and that failure to follow all instructions on this application will render my application incomplete. Incomplete applications will not be processed.

SIGNATURE: _____ Date: _____

Dues Option: ☐ New Member ☐ Two-Year Member ☐ Renewal — NSNA Member # _____
(See dues schedule **www.nsna.org/membership.html**)

The following information is very important. Please print.

First Name _____ Last Name _____

Mailing Address (Do Not Abbreviate) _____

City _____ State _____ Zip _____

Preferred Phone Number _____

NSNA policy requires that you provide your email address (and alternate email address only if it is different from primary email).
See the NSNA Privacy Policy on www.nsna.org and click on the **MEMBERSHIP** tab.

Primary Email (Required) _____

Alternate Email (Optional) _____

[Print clearly and differentiate between the L; the number 1; the letter O; and zero (0)]

Full Name of School (Do Not Abbreviate) _____

Campus & Location _____

School City/State _____

Gender ☐ M ☐ F ☐ Other Expected Date of Graduation (Month) _____ (Year) _____

Type of program (Check one) ☐ Associate Degree ☐ Diploma ☐ Baccalaureate Pre-licensure ☐ RN to BSN ☐ Direct Entry Masters

How did you hear about NSNA?
☐ Student ☐ Dean/Faculty ☐ *Imprint®* ☐ NSNA Website

☐ NSNA Partnership Program: *Check if you would like additional information from participating partners (visit* www.nsna.org/partnership-program.html*).*
☐ School Chapter President (Check if you are the school chapter president)
Project InTouch Recruiter # _____

Optional — Please complete these questions for statistical purposes and to help NSNA provide better understanding about who our members are.

Date of Birth (Month/Day /Year) _____

Race ☐ Black or African American ☐ American Indian American Indian or Alaska Native ☐ Asian ☐ Hispanic or Latino ☐ Native Hawaiian or other Pacific Islander ☐ Mixed Race ☐ Caucasian ☐ Other

☐ Amount from Dues Schedule $ _____ Are you currently? (Check all that apply):
☐ Foundation Contribution $ _____ ☐ Pre-nursing student (taking courses to qualify to enter nursing program) ☐ Licensed Practical/Vocational Nurse
Total: _____ ☐ Registered Nurse ☐ Second Career Sudent ☐ Attend accelerated pre-licensure program

Method of Payment ☐ Check ☐ Money Order ☐ MasterCard ☐ Visa

Credit Card No. _____ Expiration Date (Month) _____ (Year) _____

Billing Address _____ State _____ Zip _____

Signature _____ Print Name _____

Mail the completed application form and payment to: National Student Nurses' Association, Box 789, Wilmington, Ohio 45177.
For credit card payment, fax the application to 937.383.4511 or email applications to membership@nsna.org and call in with credit card information to 937.383.4710.