OFFICE USE ONLY:

E.D. Aprvd ___________________
Board Aprvd ___________________

Amt Rcd _____________________
Date Ck#

Membership Application

Criteria for Membership:

1. FULL MEMBER - Registered Nurses as defined below. Please check one:

___ A. Hold or aspire to hold an organizational role of administration/management who are accountable for strategic, operational and/or performance outcomes in sites where health care is delivered.
___ B. Hold faculty positions in nursing programs.
___ C. Are consultants in nursing administration/management practice.
___ D. Are editors of professional nursing journals.
___ E. Are leaders in regulatory and other nursing and health care organizations.

2. NEW MEMBER – Registered Nurses

__ 1st time discounted membership as defined under Full Member

3. Student Member – Associate members in the Organization shall be registered nurses who are:

__ Students enrolled in a graduate degree program.

4. Retired Member

__ Full IONE member who is retired from the profession and has maintained IONE membership for a period of five consecutive years prior to their application.

5. Affiliate Member – An Individual who is not a registered nurse.

__ An affiliate member may be a non-nurse professional or any healthcare consumer member of the corporate or political community who is interested in working towards advancement of the healthcare system driven by the needs of patients.

6. Industry Partner – An educational institution, healthcare institution or organization.

__ Industry Partner memberships will include educational institutions, healthcare institutions, and organizations wishing to support the mission and vision of IONE through Industry Partner membership.

Are you a member of AONE? _____ Would you like information about AONE? _____

DUES: Full Member $95_____ New Member Discount $50______ Student Member $50______
Retired Member $50_____ Affiliate Member $95_____ Industry Partner $250_______

*Demographics (optional)
__White __Hispanic __Black/African American __Asian __Native American__ Other

Return completed application form with check to: IONE, 500 North Meridian St., Suite 250, Indianapolis, IN 46204
***Make check payable to: Indiana Hospital & Health Association, c/o IONE.**

Name: ____ Telephone: ________________________________

Title: ____ County: ________________________________

Organization: __________________________________ IONE District: ____________________________

Address: ______________________________________

_______________________________________ E-Mail Address: ____________________________

Applicant Signature: ____ Date: ______________________

Revised 2019