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
   __ First time discounted membership as defined under Full Member

3. Student Member – Associate members in the Organization are:
   __ Students enrolled in a nursing degree program.

4. Retired Member
   __ Full IONL 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 IONL through Industry Partner membership.

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

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 IONL.

Name: __________________________________________ Telephone: ________________________________
Title: ____________________________________________ County: ____________________________________
Organization: ____________________________________ IONL District: _______________________________
Address: _________________________________________
_________________________________________ E-Mail Address: ______________________________

Applicant Signature: _________________________________________________ Date: _______________________

Revised 2020