



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

- 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: _____