



MEMBERSHIP APPLICATION

Date: _____ **You may publish my information among members only Yes No

Applicant/Credentials _____

Employer _____

Title/Specialty/Position _____

Mailing Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

E-mail _____

Work Phone _____ Fax _____

Active Faith Community Nurse: No Yes Paid Unpaid # hrs _____

Denomination _____

Faith Community _____

On what community organizations/committees do you serve (Turning Point, SafeKids, ONA): _____

Membership:

Regular: Registered nurses eligible for licensure in the state of Oklahoma \$60. Full membership benefits. (Bylaws are located at www.fcnaok.org)

Associate: Health ministers and other professionals \$30. All membership benefits except voting.

FCNA OK is a *501c3 entity* and is thus able to accept tax deductible donations. I would like to make an additional contribution to FCNA OK in the amount of \$_____. Thank you for your donation.

Annual membership fees are due at the October Quarterly Membership meeting. Membership year is calendar year. Payment should be accompanied by a completed membership form. Forms and checks may be mailed to:

FCNA OK Treasurer, Attn: Lana Bolhouse, 14209 SE 75th, Oklahoma City, OK 73150, 405-458-9035, fcnaok@gmail.com