American Association of Critical Care Nurse

Northwest Chicago Area Chapter
Membership Application
P.O. Box 1163
Arlington Heights, Illinois 60006-1163
630-624-5673

PLEASE TYPE OR PRINT INFORMATION

Name _____ Date _____
Address _____
City, State _____ Zip _____
Phone: Home ( ) _____
Work ( ) _____

E-mail address _____
AACN # _____ Exp _____
CCRN # _____ Exp _____
CCNS # _____ Exp _____

Employer _____ Position _____
Area(s) in which employed _____

Education: ☐ Diploma ☐ Associate ☐ BSN ☐ MSN ☐ APN ☐ Other

Committee Interest
Audit By-laws/Nominating ☐
Awards and Scholarships ☐
Program ☐ Hospitality ☐
Membership ☐
Newsletter ☐
Health Policy and Legislation/Marketing ☐

Annual Membership Dues $15.00
Or 2 years for only $25.00 new ☐ renewal ☐

Recruited by: _____

ENCLOSE WITH APPLICATION: PHOTOCOPY OF AACN NATIONAL MEMBERSHIP CARD

CK ☐ Online ☐
Cash ☐
Date _____