

## You are cordially invited to join WIN!

If you are already a member, please share this membership application with a colleague.

### Type of Membership

(Please mark the box corresponding to the type of membership you are selecting.)

\*Membership includes a subscription to "Nursing Research."

- |  |                 |   |       |
|--|-----------------|---|-------|
| <input type="checkbox"/> Individual Membership *         | \$145           | <input type="checkbox"/> Agency Membership*   | \$800 |
| <input type="checkbox"/> Associate Individual Membership | \$ 60           | (Nursing education programs & organized nursing practices with parent organization geographically located in one of the 13 Western states.) |       |
| <input type="checkbox"/> Student Membership*             | \$ 80           | <input type="checkbox"/> Associate Agency Membership  | \$200 |
| <input type="checkbox"/> Retired Nurse Membership        | \$ 60           | (Organization, agency or business other than above which supports the mission of WIN.)  |       |
| <input type="checkbox"/> Contributor                     |                 |   |       |
| Benefactor   | \$2,500 or more |   |       |
| Friend   | \$500 - \$2,499 |   |       |
| Sponsor  | \$200 - \$499   |   |       |

### Membership Information

Name: \_\_\_\_\_ Credentials: \_\_\_\_\_

Title: \_\_\_\_\_

Employer/Agency: \_\_\_\_\_

Work Address: \_\_\_\_\_

Phone: \_\_\_\_\_ FAX: \_\_\_\_\_ Email: \_\_\_\_\_

Home Address: \_\_\_\_\_

Phone: \_\_\_\_\_ FAX: \_\_\_\_\_ Email: \_\_\_\_\_

Preferred address for mailings:  Work  Home

I give my permission for my name, work address, work phone, work FAX number and email address to be printed in the WIN Membership Director, unless marked here:

### Payment Information

Payment is made by the following method:

- Check made payable to the "Western Institute of Nursing" and enclosed.
- Credit Card:
- VISA  Mastercard

Card Number: \_\_\_\_\_

Name of Cardholder: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Signature: \_\_\_\_\_

**Please submit completed form with credit card information or check made payable to WIN to:  
Western Institute of Nursing, SN-4N, 3455 SW Veterans Hospital Road, Portland, OR 97239-2941**