

**NURSE PRACTITIONERS OF NORTHEASTERN PA
MEMBERSHIP APPLICATION**

Please Print

___ New Member

___ Renew Membership

NAME _____

ADDRESS _____

HOME/CELL PHONE _____ WORK PHONE _____

FULL MEMBER ___ STUDENT MEMBER ___ RETIREE ___

CRNP LICENSE NUMBER _____ RN LICENSE NUMBER _____

DEGREE BSN ___ MSN ___ PhD ___ OTHER ___

ARE YOU NATIONALLY CERTIFIED? YES ___ NO ___

IF YES, BY WHICH CERTIFYING BODY? ANCC ___ AANP ___

AREA OF CERTIFICATION _____

WORK SETTING Hospital ___ MD/DO Office ___ School/University ___ Faculty ___

Home Health/Hospice ___ Administration ___ Family Planning center ___ Retail Clinic ___

Occupational Health ___ Long Term Care ___ Retired ___ Inactive ___ Other _____

DO YOU HAVE PRESCRIPTIVE AUTHORITY? YES ___ NO ___

DO YOU HAVE A DEA NUMBER? YES ___ NO ___

DO YOU HAVE A WRITTEN PRACTICE AGREEMENT? YES ___ NO ___

DO YOU COLLABORATE WITH AN MD ___ DO ___ BOTH ___

DO YOU SERVE AS A PRECEPTOR? YES ___ NO ___

PLEASE MAIL COMPLETED APPLICATION FORM AND CHECK PAYABLE TO "NURSE PRACTITIONERS OF NEPA" FOR \$25.00 TO:

ROBIN GALLAGHER
1636 BIRCH STREET
SCRANTON PA 18505

ANNUAL MEMBERSHIP FEE DUE BY DECEMBER 31ST TO REMAIN AN ACTIVE MEMBER IN THE ORGANIZATION.