

Agency Supporter Membership Application

Enroll me as an Agency Supporter member of the New Jersey League for Nursing

(Please Note: Membership in the National League for Nursing (NLN) does not make you a member of the New Jersey League.)

PLEASE PRINT:

COMPANY: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

1 CONTACT PERSON:

NAME: _____

POSITION: _____ DEPARTMENT: _____

PHONE: () _____ EXT: _____ FAX: () _____

E-MAIL: _____ @ _____

2 CONTACT PERSON: (Not Required)

NAME: _____

POSITION: _____ DEPARTMENT: _____

PHONE: () _____ EXT: _____ FAX: () _____

E-MAIL: _____ @ _____

DUES: () \$ 150 AGENCY SUPPORTER MEMBERSHIP

We would like to make an additional donation to NJLN. Contributions of any amount will help support the mission and goals of NJLN. (All contributions are tax deductible as allowed by law.)

() \$ 25 () \$ 50 () \$ 100 () \$ _____ other amount

Total Amount of Check or Credit Charge: \$ _____

() Check enclosed payable to: "NJLN"

() Charge to: () Visa () Mastercard () American Express

ACCT: # _____ Exp. Date: _____

Security Code (required): _____ Print Name on Card: _____

Credit Card Billing Address (if different than address above):

Print Form and Register Via:

Tel: 908-789-3398

Fax: 908-789-0727

Mail: New Jersey League for Nursing, P.O. Box 165, Garwood, NJ 07027