



Membership Application | Page 1 of 2

You may also apply online through our Web site: www.sgna.org

CONTACT INFORMATION (Please print or type) * Required field

* First _____ * MI _____ * Last _____

* Hospital/Office/Company Name _____

*** CREDENTIALS**

Education: PhD MSN MS
 BSN BS ADN
 DIPL

Nursing: RN LPN LVN

Certification: CGRN CGN
 Other _____

Certification Date: _____

Other Training: Technician Nursing Assistant

Please provide both addresses and check your preferred mailing address:

Work

* Street Address _____

* City _____

* State/Province _____ * ZIP _____

* Country _____

* Phone _____

Fax _____

Home

* Street Address _____

* City _____

* State/Province _____ * ZIP _____

* Country _____

* Phone _____

* E-Mail Address _____

REFERRED BY _____

(Members who refer other members will be entered into an annual prize drawing.)

The following information will be used for demographic purposes only. Your response is optional but appreciated.

Gender: Male Female

Ethnicity: African-American Asian Caucasian Hispanic/Latino
 Native American Pacific Islander Other _____
 Do Not Care To Respond

Date of Birth _____

*** PROFESSIONAL PROFILE**

1.) Professional Setting (Check one)

Free Standing/ Ambulatory Equipment Sales
 GI Clinic GI Nursing Unit
 Inpatient Only Outpatient Only
 Inpatient/Outpatient Combination Manufacturer
 Physician's Office
 Other _____

2.) * Position (Check one)

Administrator/ Director Clinical Specialist
 Consultant Educator
 Nurse Manager Researcher
 Staff Nurse Nurse Practitioner
 Supervisor/ Coordinator Sales
 Technician
 Other _____

3.) Memberships in Other Nursing Organizations (Check all that apply)

ANA/SNA AACN
 ENA ASPAN
 AORN Sigma Theta Tau
 Other _____

4.) Primary Patient Population

Adult Pediatric Both

5.) Year I Began My Nursing Career

6.) Year I Began My Career in GI/endoscopy

7.) My Current Position Is

Full-time Part-time

PAYMENT INFORMATION • dues subject to change

A. Membership (SGNA membership runs on a **calendar year** from January 1 to December 31.) If you are applying mid-year please indicate the 18-month option below. Check the category of membership for which you are applying:

Voting Status	Type	Definition	Annual Dues	Two-Year Dues	18-Month Dues (Available July 1)
<input type="checkbox"/> Voting	Licensed Nurse	Limited to Registered Nurses and Licensed Vocational/ Practical Nurses involved in or associated with gastroenterology and/or endoscopy nursing practice	\$120	\$225	\$195
<input type="checkbox"/> Voting	Associate	Limited to Assistive Personnel; such as technicians, technologists and assistants involved in or associated with gastroenterology and/or endoscopy nursing practice	\$120	\$225	\$195
<input type="checkbox"/> Non-Voting	Affiliate	Includes, but is not limited to, physicians, consultants, industry representatives and educators involved in or associated with gastroenterology and/or endoscopy nursing practice	\$105	\$210	\$165
<input type="checkbox"/> Non-Voting	Non-Practicing	Limited to those that have retired from the GI/endoscopy nursing field but want to continue to receive benefits and information regarding this profession	\$60	\$120	\$90

SUBTOTAL A _____

B. Regional Societies

All voting members residing in the U.S. are required to affiliate with an SGNA regional society.

Regional Society preference: _____

Regional Society Dues: **Voting Licensed Nurses and Associates**
No additional payment needed
Included in Annual Dues Amount

Non-Voting Affiliate and Non-Voting Non-Practicing
Optional payment; if interested, please indicate
preferred region above and remit an additional \$15

SUBTOTAL B (If applicable): _____

C. E-SIGs (Electronic Special Interest Groups) — FREE!
Please **CHECK** box if you would like to join SGNA's e-SIGs and circle the group(s) of particular interest. These are online special interest groups only. For more information on SGNA e-SIGs visit www.sgna.org.

- | | |
|-------------------------------|--------------------------|
| Advanced Practice | Legislative |
| Ambulatory GI Practice | Manometry |
| Associates | Nurse Endoscopist |
| Capsule Endoscopy | Pediatric |
| Endoscopic Ultrasound | Pulmonary |
| ERCP | Research |
| Hepatology | University |
| Lab Management | VA Nurses |
| LPN/LVN | |

Total Dues and Method of Payment

TOTAL A + B = _____

Check enclosed for (amount) _____

Charge to credit card (Check one.)

Visa MasterCard American Express

Name as it appears on card _____

Card # _____

Exp Date _____

Signature _____

Please mail your completed application and payment to:

**SGNA Headquarters, 3943 Paysphere Circle, Chicago, IL 60674
OR fax credit card information to: 312/673-6694. If paying by check, please send in a sealed envelope.**

Contributions or gifts to SGNA are not tax deductible as charitable contributions for income tax purposes, but may be deductible as a business expense. Please consult your tax advisor. SGNA Federal I.D. #51-014-9057.