HMA Membership Form
FCN Educator Discount Version

*FCN Educator Name (Print) _____ Signature _____ Date _____
*Denotes required data
.

NEW MEMBERSHIP *☐
List Credentials: _____ Title: _____

*PRINT: _____
Last Name First Name Middle Initial

*ADDRESS: _____

*ADDRESS: _____
Street or P. O. Box, incl. apartment # City State Zip

*MEMBERSHIP CATEGORY: (Check top 2 Membership Categories & Circle either 1st or 2nd for each)

☑ (Choose top 2)	Circle (Primary or Secondary)	
☐ Faith Community Nursing	1st	2nd State of Nursing Licensure: _____
☐ Health Ministry	1st	2nd
☐ Program Leadership	1st	2nd
☐ Spiritual Leadership	1st	2nd
☐ Other	1st	2nd _____

*1st PHONE: _____ H, Cell, Wk 2nd PHONE: _____ H, Cell, Wk

*EMAIL: _____

LOCATION OF PRACTICE: (i.e. List the Primary and Secondary Organization/Faith Community Name)

*1st _____ 2nd _____

*FAITH GROUP: **(**Check one and list Denomination/Sect)

☐ Christian	D/S _____
☐ Hindu	D/S _____
☐ Jewish	D/S _____
☐ Muslim	D/S _____
☐ Other _____	D/S _____

☐ *(Please check) I Understand that HMA will send me information and activities related to HMA.

FEES: FCN FOUNDATION COURSE DISCOUNT $85.00

*Payment Type: Check/Cash ☐ Money Order ☐ Credit Card ☐ (Circle) Visa, Mastercard, Discover, AmExpress

Name on Card _____ # _____

Exp. Date ___/___ **Sec. Code** _____ **Signature** _____

Health Ministries Association, Inc. PO Box 60042 • Dayton, OH 45406 1-800-723-4291 http://hmassoc.org