HMA Membership Form

*Denotes Required. Date _____

*Check One: ☐ NEW or ☐ RENEWAL Membership # or Username _____

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

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

List Credentials: _____ Title: _____

*PRINT: _____
Last Name First Name Middle Initial

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

*1° PHONE: _____ H, Cell, Wk 2° PHONE: _____ H, Cell, Wk

*EMAIL: _____

LOCATION OF PRACTICE: (i.e. List the Primary and Secondary Organization/Faith Community Name)
*1° _____ 2° _____

*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: (circle one group membership level)

Group of 10 - 20	$85.00/person	Group of 51 – 100	$60/person
Group of 21 - 50	$70.00/person	Group > 100	$55/person

*All membership forms must be batched and submitted with one payment.

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

Name on Card _____ # _____

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