

Membership Application

Society of Otorhinolaryngology & Head-Neck Nurses



FOR OFFICE USE ONLY

Date Rec'd _____
 Code _____
 Chapter _____
 Ck #/cc _____
 Processed _____

207 Downing Street ~ New Smyrna Beach, FL 32168
 Phone ~ 386-428-1695 Fax ~ 386-423-7566
 Email~sohnnnet@aol.com Website~www.sohnnurse.com

Please Print Legibly

Miss _____
 Mrs. _____
 Ms. _____
 Mr. Last Name First Name Initial

Preferred Mailing Address: ___ home ___ business
 Home Address _____ Apt# _____
 City _____ State _____
 Zip _____ Country _____

Home Telephone: _____

Area of Practice

___ Allergy (AL) ___ Otolaryngology (OTO)
 ___ Head & Neck Oncology (HN) ___ Pediatric ORL (PED)
 ___ Multi-ORL (ORL) ___ Plastics (PL)
 ___ Multi-Specialty Unit (MSU) ___ Other (OT) _____

Practice Setting

___ Ambulatory Surgery (AMB) ___ Operating Room (OR)
 ___ Home Health (HH) ___ Outpatient Clinic (OUT)
 ___ Hospital (HS) ___ Physicians Office (OFC)
 ___ Federal/ Military (MIL) ___ Other (OT) _____
 ___ Long Term Care (LTC)
 ___ Full Time ___ Part Time ___ Retired

Permission to include your membership information in the SOHN Membership Directory (secure SOHN Members area of the website) and mailing lists:
 (Please initial) ___ Yes ___ No

Are you a member of another nursing organization?
 (Ex. AORN, ANA, etc.) If yes, which one(s)? _____

Total years in:
 Nursing _____ ORL Nursing _____ SOHN _____

DUES

SOHN Membership Year ~ March 1 – February 28
 Membership includes professional Journal and Newsletter
 Full Member – RN – Voting Member \$100.00
 Associate Member – LPN/LVN – Non-Voting \$100.00
 Retired \$ 50.00
 Chapter Dues (please indicate which chapter below) \$ 5.00
 Late Renewals (after March 1) \$110.00
 Two Year Renewal \$190.00
 Two Year Renewal with Chapter \$200.00
 Subscription only – US \$ 50.00
 Subscription only – Foreign \$ 55.00
 Donation to the ENT Nursing Foundation \$ 30.00
 Other ENT-NF Donation Amount \$ _____
 Amount Paid \$ _____

Chapters

___ Atlanta Regional (ATL) ___ North Carolina (NC)
 ___ Birmingham, AL (BIR) ___ Pittsburgh (PGH)
 ___ Chicago (CHI) ___ St. Louis (SLC)
 ___ Grand Rapids (GRC) ___ South Carolina (Low Country) (SC)
 ___ Greater Cleveland (CLV) ___ SE Pennsylvania (SEP)
 ___ Greater Houston (HSN) ___ Wisconsin (WIS)
 ___ Heartland/ Iowa (HRC)
 ___ Maryland/DC (MDC)

Referred by _____

Credential(s) you presently use following your name _____

Employer Name _____

Employer Address _____

City _____ State _____

Zip _____ Country _____

Work Telephone: _____

Fax: _____

Email: _____

Highest Level of Education

___ LPN/LVN Certificate (LPN) ___ Associate, Nursing (ASN)
 ___ Diploma (DIP) ___ Bachelors, Other (BS)
 ___ Bachelors, Nursing (BSN) ___ Masters, Other (MS)
 ___ Masters, Nursing (MSN) ___ Doctoral, Other (PHD)
 ___ Doctoral, Nursing (PHDN)
 ___ Other (OT)

Special Interest Groups

___ Advanced Practice (AP) ___ Head & Neck (HN)
 ___ Allergy/ Sinus (AL) ___ Office/ Outpatient (OUT)
 ___ Facial Plastics (FP) ___ Otolaryngology (OTO)
 ___ Federal/Military (MIL) ___ Pediatric (PED)
 ___ Geriatric (GER) ___ Perioperative (OR)

Please make checks payable to: SOHN

Credit Card Information
 American Express ___ Discover ___ Master Card ___ VISA ___
 Exp. Date _____

Account # _____

VIN# (Last 3 numbers from back of card) _____

Signature _____

Mail to:

SOHN
 207 Downing Street
 New Smyrna Beach, FL 32168

Fax to:

386-423-7566

Online: Join or Renew at www.sohnnurse.com