MEMBERSHIP
APPLICATION / RENEWAL
YEAR 2010

___ New ___Renewal

NAME _____**PROFESSIONAL DESIGNATIONS** _____

FACILITY OR ORGANIZATION _____**TITLE** _____

MAILING ADDRESS: **STREET** _____

CITY _____

STATE _____ **ZIP CODE** _____

TELEPHONE NUMBERS: **WORK** (_____)_____ **FAX** (_____)_____ **HOME** (_____)_____**(OPTIONAL)**

E-MAIL ADDRESS: _____

Area of Focus:

__ **Long term Care** __ **Community Health** __ **Nursing QA/QM** ___**Risk Management**
__ **Utilization Mgt.** __ **Infection Control** __ **Hospital-wide QA/TQM/CQI** ___**Other(specify)** _____

Signature _____ **Date**_____

APIC Member ___ **YES** ___ **NO** **CIC** ___**YES** ___ **NO**

DUES: $30 Yearly. Dues payable by Dec 31, 2009. Please make **checks payable to ICPSNE, Inc.**

Send to: Nancy Vallande
55 Vermont Street
Cranston, RI 02920

Date Rec'd:_____
Amount Rec'd:_____
Check #:_____
Initials:_____