



MEMBERSHIP APPLICATION / RENEWAL YEAR 2011

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 Other(specify) _____
QA/TQM/CQI

Signature: _____ Date: _____

APIC Member YES NO CIC YES NO

DUES: \$30 Yearly. Dues payable in January. Please make checks payable to ICPSNE, Inc. Mail to:
Mary Ellen Casey, RNC, M.Ed
Women & Infants Hospital
Infection Control Department
101 Dudley Street
Providence, RI 02903

Date rec'd _____
Amount rec'd _____
Check # _____
Initials _____