SGNA
Society of Gastroenterology Nurses and Associates, Inc.

Membership Application |

You may also apply online through our Web site: www.sgna.org

CONTACT INFORMATION (Please print or type.)

First ______ MI ______ Last ______

Hospital/Office/Company Name ______

License # ______ State Certified ______

Credentials

Education: ☐ PhD ☐ MSN ☐ MS ☐ BSN ☐ BS ☐ ADN ☐ DIPL

Nursing: ☐ RN ☐ LPN ☐ LVN

Certification: ☐ CGRN ☐ CGN ☐ Other______

Certification Date:______

Other Training: ☐ Technician ☐ Nursing Assistant

Please provide both addresses and check your preferred mailing address:

☐ **Work**

Street Address______

City______

State/Province______ Zip______

Country______

Phone______

Fax______

☐ **Home**

Street Address______

City______

State/Province______ Zip______

Country______

Phone______

E-Mail Address______

REFERRED BY______

(Members who refer other members will be entered into an annual prize drawing.)

The following information will be used for demographic purposes only. Your response is optional but appreciated.

Gender: ☐ Male ☐ Female

Ethnicity: ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic/Latino ☐ Native American ☐ Pacific Islander ☐ Other______ ☐ Do Not Care To Respond

Date of Birth ______

PROFESSIONAL PROFILE

1.) Professional Setting (Check one.)

☐ Free Standing/ Ambulatory
☐ Equipment Sales
☐ GI Clinic
☐ GI Nursing Unit
☐ Inpatient Only
☐ Outpatient Only
☐ Inpatient/Outpatient Combination
☐ Manufacturer
☐ Physicians Office
☐ Other______

2.) Position (Check one.)

☐ Administrator/ Director
☐ Clinical Specialist
☐ Consultant
☐ Educator
☐ Nurse Manager
☐ Researcher
☐ Staff Nurse
☐ Nurse Practitioner
☐ Supervisor/ Coordinator
☐ Sales
☐ Technician
☐ Other______

3.) Memberships in Other Nursing Organizations (Check all that apply.)

☐ ANA/SNA
☐ AACN
☐ ENA
☐ ASPAN
☐ AORN
☐ Sigma Theta Tau
☐ Other______

4.) Primary Patient Population

☐ Adult ☐ Pediatric ☐ Both

5.) Year I Began My Nursing Career

______

6.) Year I Began My Career in GI/Endoscopy

______

7.) My Current Position Is

☐ Full-time ☐ Part-time

PAYMENT INFORMATION • *dues subject to change*

A. Membership (SGNA membership runs on a **calendar year** from January 1 to December 31 of the following year.) If you are applying mid-year please indicate the 18 month option below.

Check the category of membership for which you are applying:

Voting Status	Type	Definition	Annual Dues	Two-Year Dues	18 Month Dues (July 1 - October 1)
☐ Voting	Licensed Nurse	Limited to Registered Nurses and Licensed Vocational/ Practical Nurses involved in, or associated with, gastroenterology and/or endoscopy nursing practice	$120	$225	$195
☐ Voting	Associate	Limited to Assistive Personnel - technicians, technologists, assistants involved in, or associated with, gastroenterology and/or endoscopy nursing practice	$120	$225	$195
☐ Non-Voting	Affiliate	Includes, but is not limited to, physicians, consultants, industry representatives, educators involved in, or associated with, gastroenterology and/or endoscopy nursing practice	$105	$210	$165

SUBTOTAL A ______

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B. Regional Societies
All voting members residing in the U.S. are required to affiliate with an SGNA regional society.

Regional Society preference:____

Regional Society Dues:

Voting Licensed Nurses and Associates
No additional payment needed
Included in Annual Dues Amount

Non-Voting Affiliate
Optional payment, if interested please indicate preferred region above and remit an additional $15 (If after July 1, remit $7.50)

SUBTOTAL B (If applicable):____________________

C. E-SIGs (Eletronic Special Interest Groups) FREE!
Please **CHECK** box if you would like to join SGNA's e-SIGs and circle the groups of particular interest. This is an on-line special interest group only. For more information on SGNA e-SIGs visit www.sgna.org/resources/esigs.cfm.

Advanced Practice

Ambulatory GI Practice

Associates

Capsule Endoscopy

Endoscopic Ultrasound Nursing

ERCP

Hepatology

Lab Management

Legislative

LPN/LVN
Manometry

Nurse Endoscopist

Pediatric

Pulmonary

Research

University

VA Nurses

Method of Payment
TOTAL A + B =____________________

☐ Check enclosed for (amount):____________________

☐ Charge to credit card (Check one.):

☐ Visa ☐ MasterCard ☐ American Express

Name as it appears on card:____________________

Card #:____________________

Exp Date:____________________

Signature:____________________

Please mail your completed application and payment to:

SGNA Headquarters, 3943 Paysphere Circle, Chicago, IL 60674 OR fax credit card information to: 312/673-6694. If paying by check, please send in a sealed envelope.

Contributions or gifts to SGNA are not tax deductible as charitable contributions for income tax purposes, but may be deductible as a business expense. Please consult your tax advisor. SGNA Federal I.D. #: 51-014-9057.