



International Society of Psychiatric-Mental Health Nurses

2424 American Lane • Madison, WI 53704-3102 USA • Phone: 1-608-443-2463 • Fax: 1-608-443-2474

ISPN Membership Application

Please complete the following information and mail, fax or email (no purchase orders) to:
Mail: ISPN Membership, 2424 American Lane, Madison, WI 53704, USA
Fax: +1-608-443-2474 or +1-608-443-2478
Email: info@ispn-psych.org

Registration Information

First Name: _____

Last Name: _____

Credentials: _____ Title: _____

Affiliation: _____

Affiliation Address: _____

City: _____

State/Province: _____ Zip/Postal Code: _____

Country (if other than USA): _____

Home Address: _____

City: _____

State/Province: _____ Zip/Postal Code: _____

Country (if other than USA): _____

Preferred Mailing Address: Affiliation Home

Home Phone: _____ Daytime Phone: _____

Email: _____

The following line of questions are optional and for demographic analysis only:

Gender: Female Male Non-Binary Other Do Not Wish to Respond

Race/Ethnicity: _____ Do Not Wish to Respond

Primary Language: _____

Highest Degree: _____ Years in Practice: _____

Are you a Student? Yes* No

*Students must provide verification of student status

Referring Member (optional): _____

Are you an ANA member? Yes No If YES, ANA membership number: _____

Are you a member of an honor societies (e.g. Sigma Theta Tau, etc.)? Yes No

If so, which honor societies? _____

Are you an ISPN liaison to any professional groups or organizations (if yes, please list):

What certifications do you hold?

Adult PMHNP Family PMHNP Adult PMHCNS

Child PMHCNS Other: _____

Do you have prescriptive authority in your state, territory or country? Yes No

Do you teach a PMHNP or PMH DNP program? Yes No

If yes, Name of Program: _____

Do you direct a PMHNP or PMH DNP program? Yes No

If yes, Name of Program: _____

Have you been published? Yes No

If yes, in what Journal(s)? _____

Have you been funded for projects or research? Yes No

My Area of Expertise is (select one):

Clinical Research Nursing Education

My Primary Work Setting is (select one):

- | | |
|---|---|
| <input type="checkbox"/> Behavioral Care Company/HMO | <input type="checkbox"/> Military |
| <input type="checkbox"/> Community Agency /organization | <input type="checkbox"/> Primary Care Office |
| <input type="checkbox"/> Community Health Center | <input type="checkbox"/> Prison/Jail |
| <input type="checkbox"/> Emergency Services | <input type="checkbox"/> Private Investor-owned Hospital |
| <input type="checkbox"/> Employee Assistance | <input type="checkbox"/> Public/Federal Hospital |
| <input type="checkbox"/> Home Health Agency | <input type="checkbox"/> Private Practice |
| <input type="checkbox"/> Industry | <input type="checkbox"/> School/College/Department of Nursing |
| <input type="checkbox"/> Mental Health Care Clinic | Other: _____ |

My Primary Setting Role is (select one):

- | | |
|--|---|
| <input type="checkbox"/> Administration (organizational) | <input type="checkbox"/> Manager/Assistant manager (clinical) |
| <input type="checkbox"/> Case Manager | <input type="checkbox"/> Nurse Practitioner |
| <input type="checkbox"/> Clinical Educator | <input type="checkbox"/> Researcher |
| <input type="checkbox"/> Clinical Nurse Specialist | <input type="checkbox"/> Staff Nurse |
| <input type="checkbox"/> Consultant | <input type="checkbox"/> Therapist |
| <input type="checkbox"/> Consultation Liaison | Other: _____ |
| <input type="checkbox"/> Faculty – Academic | |

Practice area of interest is: _____

Are you interested in serving on a task force / committee / speaking in this area?
 Yes No

Practice area of interest is: _____

Are you interested in serving on a task force / committee / speaking in this area?
 Yes No

My Clinical Interest is (Check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Substances Abuse/Dependency |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Alzheimer's/Dementia |
| <input type="checkbox"/> Autism Spectrum Disorders | <input type="checkbox"/> Sleep Disorders |
| <input type="checkbox"/> Behavior Therapies | <input type="checkbox"/> Obesity/Weight Loss/Fitness |
| <input type="checkbox"/> Bipolar Disease | <input type="checkbox"/> Complementary/Alternative Therapies |
| <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> General Psych-Mental Health | <input type="checkbox"/> Mental Health promotion/wellness |
| <input type="checkbox"/> Psych-Mental Health Other: Specify | <input type="checkbox"/> Undecided |
| <input type="checkbox"/> PTSD | <input type="checkbox"/> Other please explain: _____ |
| <input type="checkbox"/> Schizophrenia/Personality Disorders | _____ |
| <input type="checkbox"/> Sexual Abuse | |

Are you interested in serving on a task force / committee / speaking in this / these area (s)? Yes No



International Society of Psychiatric-Mental Health Nurses

2424 American Lane • Madison, WI 53704-3102 USA • Phone: 1-608-443-2463 • Fax: 1-608-443-2474

My Population Focus is (check all that apply):

- Child
- Adolescent
- Adult
- Geriatric
- LGBTQ
- Ethnic/Racial minority/Immigrant; specify _____
- Homeless/Underserved
- Family
- Lifespan

How did you hear about ISPN? _____

I am interested in participating in the following: (optional):

- Awards Committee
- Communications & Marketing Committee
- Conference Committee
- Diversity & Equity Committee
- SIG: Psychiatric-Mental Health Policy
- SIG: APN Formation
- Task Force
- Finance Committee
- Membership Committee
- Nominating Committee
- SIG: Psychiatric Consult. Liaison Adv. Nursing Practice

Member Rates

- Full Member \$150
- Full Member International \$75 (first year only, after first year \$150/year)
- Student Member* \$35
- Retired Member \$60

*Students must provide verification of student status (copy of ID, class schedule, etc.).

Charitable Donation

If you are interested in making a donation to the ISPN Foundation, select any Donation Type and any Amount:

Donation Type:

- General Contribution
- Mental Health and Wellness Research Scholarship
- Joyce Fitzpatrick Psychiatric Nursing Research Grant
- Susan McCabe Lecture Fund
- Greatest Need
- None

Amount:

- \$1,000
- \$500
- \$200
- \$100
- \$50
- \$25
- Other Amount: \$ _____

Periodically corporations, institutions, and healthcare recruitment agencies ask ISPN to provide the ISPN membership for mailings. Please check here if you do not wish your name and address to be included:

- Please do not release my name and address to corporations, institutions, or agencies outside of ISPN.

May ISPN send you Society updates, such as conference abstract submission opening and closing dates; Award and Officer nomination, election results; and conference information (hotels, registration, program/schedule updates, etc.)?

- Yes, I would like to OPT IN

Fees Due

Membership Fee \$ _____

Charitable Donation \$ _____

Total Amount Due \$ _____

Payment Options

- Check (payable to ISPN; US Funds only)
- MasterCard/Visa/Discover

CC# _____ Expiration Date: _____

Name on Card: _____

Signature: _____