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 ant 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):

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

My **Primary Setting Role** is (select one):

❒ Administration (organizational)
❒ Case Manager
❒ Clinical Educator
❒ Clinical Nurse Specialist
❒ Consultant
❒ Consultation Liaison
❒ Faculty – Academic
❒ Manager/Assistant manager (clinical)
❒ Nurse Practitioner
❒ Researcher
❒ Staff Nurse
❒ Therapist
❒ Other: _____

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):

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

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

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My **Research Interest** is: _____
Are you interested in serving on a task force / committee / speaking in this area?
❒ Yes ❒ No

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
❒ Bridges - Student Journey to Advanced Practice
❒ Communications & Marketing Committee
❒ Conference Committee
❒ Diversity, Equity, & Inclusion Committee
❒ Policy Committee
❒ Finance Committee
❒ Membership Committee
❒ Nominating Committee
❒ Task Force

Are you willing to be a mentor for the ISPN IMIN Mentoring Program?
❒ Yes ❒ No ❒ Maybe, I need more information

Would you like to subscribe to the ISPN member e-list (listserv)?
❒ Yes, please subscribe me ❒ No, not at this time
❒ I am already subscribed

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:	Amount:
❒ General Contribution	❒ $1,000
❒ Historical Archives	❒ $500
❒ Mental Health and Wellness Research Scholarship	❒ $200
	❒ $100
❒ Joyce Fitzpatrick Psychiatric Nursing Research Grant	❒ $50
	❒ $25
❒ Susan McCabe Lecture Fund	❒ Other Amount: _____
❒ Greatest Need	
❒ None	

Periodically corporations, institutions, and healthcare recruitment agencies ask ISPN to provide the ISPN membership for mailings. Please indicate if you do or do not wish for your name and address to be included:
❒ Yes, please release my name and address to corporations, institutions, or agencies outside of ISPN.
❒ No, 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.
❒ No, I would not like to receive updates.

Members are searchable in our online Members Only Directory. Information is only shared with ISPN members. Please indicate if you would like to be listed.
❒ Yes, I would like to be listed.
❒ No, please do not list me in the Members Only Directory.

Fees Due

Membership Fee	$_____
Charitable Donation	$_____
Total Amount Due	**$**_____

Payment Options

❒ Check (payable to ISPN; US Funds only)

❒ MasterCard/Visa/Discover

CC# _____ Expiration Date: _____

CVV: _____ ZIP Code: _____

Name on Card: _____

Signature: _____