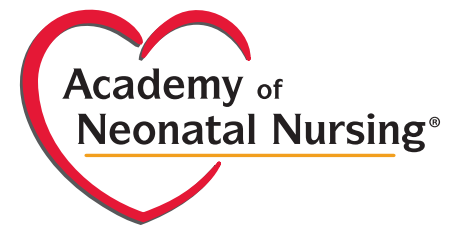


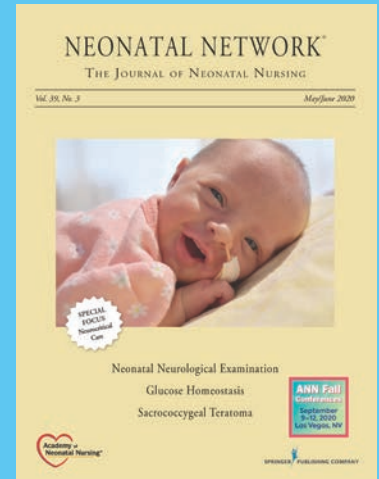
Group Membership Special Offer



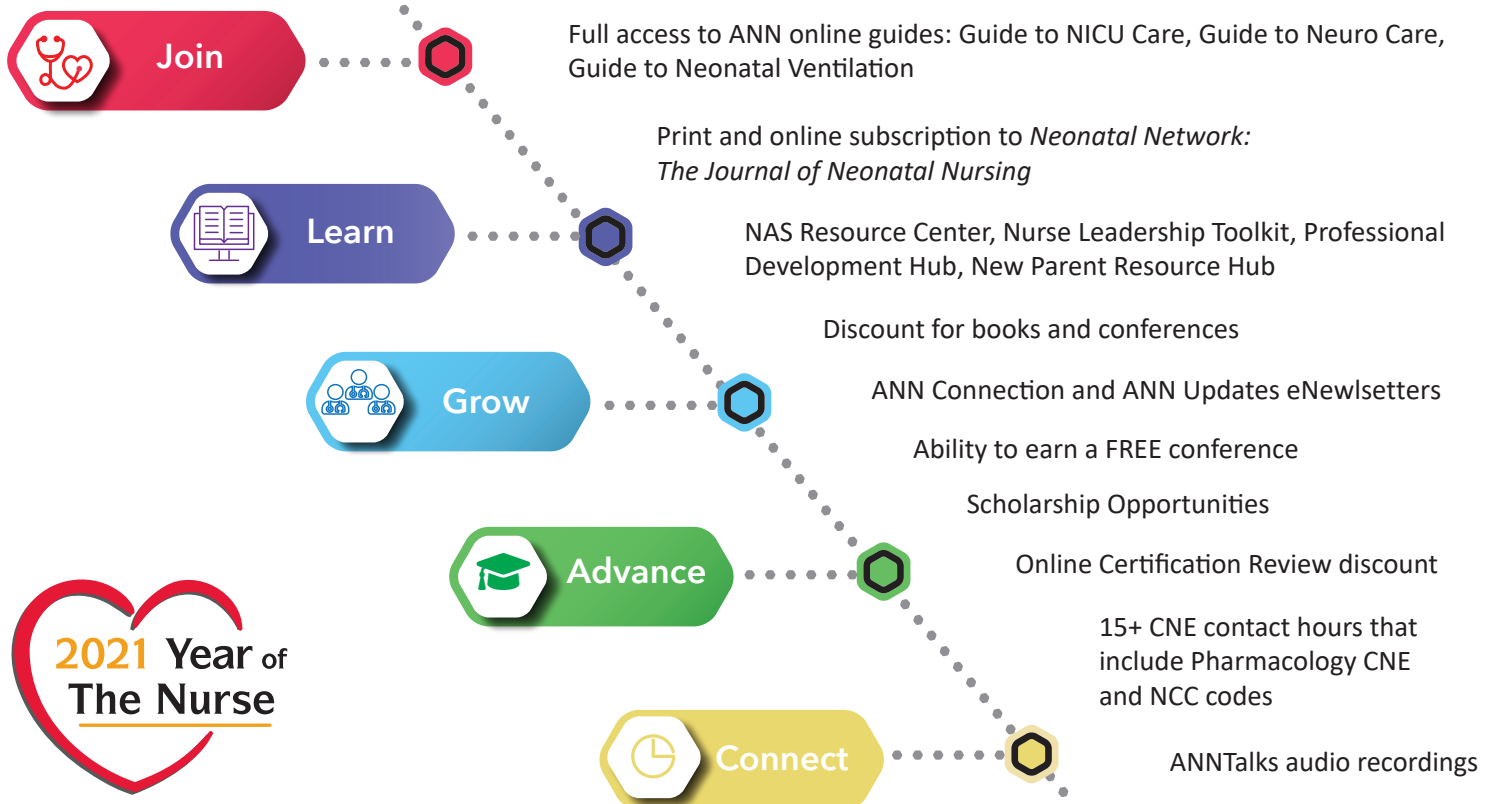
Join Together and Each Saves \$25!

Your group can include 5 new* members or a combination of 8 new and renewing members.

Pay only \$90 for a 1-year ANN membership.



Membership benefits include:



This offer is valid for 1-Year US/Canada Individual only and may not be combined with any other offer.

Memberships must be submitted together using the form on the reverse side or groups can call individually with payment over the phone, 707-795-2168.

Offer expires June 30, 2021.

* Must not have been a member of ANN for 2 or more years.

academyofneonatalnursing.org

Membership Form

This form can be used for individual or group memberships.

Questions: 707-795-2168

Member 1

Name (including credentials) _____ Phone _____
Home Address _____ City _____
State _____ Zip/Postal Code _____ Email _____
Employer/Hospital _____
Visa or MasterCard # _____ - _____ - _____ or Check # _____
Expiration date _____ Security code _____
Signature _____
Billing address (if different from above) _____

Member 2

Name (including credentials) _____ Phone _____
Home Address _____ City _____
State _____ Zip/Postal Code _____ Email _____
Employer/Hospital _____
Visa or MasterCard # _____ - _____ - _____ or Check # _____
Expiration date _____ Security code _____
Signature _____
Billing address (if different from above) _____

Member 3

Name (including credentials) _____ Phone _____
Home Address _____ City _____
State _____ Zip/Postal Code _____ Email _____
Employer/Hospital _____
Visa or MasterCard # _____ - _____ - _____ or Check # _____
Expiration date _____ Security code _____
Signature _____
Billing address (if different from above) _____

Member 4

Name (including credentials) _____ Phone _____
Home Address _____ City _____
State _____ Zip/Postal Code _____ Email _____
Employer/Hospital _____
Visa or MasterCard # _____ - _____ - _____ or Check # _____
Expiration date _____ Security code _____
Signature _____
Billing address (if different from above) _____

Member 5

Name (including credentials) _____ Phone _____
Home Address _____ City _____
State _____ Zip/Postal Code _____ Email _____
Employer/Hospital _____
Visa or MasterCard # _____ - _____ - _____ or Check # _____
Expiration date _____ Security code _____
Signature _____
Billing address (if different from above) _____

Photocopy this form as needed to accommodate your group size and submit together by FAX or mail to:

Academy of Neonatal Nursing
6366 Commerce Blvd., PMB 357 Rohnert Park, CA 94928 FAX 707-795-0786