



The Jamaica Nurses' Association of Florida, Inc.

Membership Application

Office Use Only

Date Received: _____

Fee: _____

Officer: _____

Personal Information

Please print legibly or type.

Mr. Ms. Mrs.

Social Security Number: _____

Full Name: _____
Last *First*

Address: _____
Number & Street

_____ *City* *State* *Zip*

Telephone: (_____) _____ Date of Birth: _____
Area Code *Month* *Day*

Organization/Employer: _____

License Number: _____ Work Telephone: (_____) _____
Area Code

Membership Information

Please Check One:

New Member Renewal Rejoin

Membership: (\$50)

Rejoin – membership expired greater than two years

Highest Degree Earned:

Diploma Associate Bachelor Masters Doctorate

Other _____

Indicate Committee of Interest:

Project Public Relations Social Education Building

Membership Choir

I am unable to be a member at this time but please accept my donation of:

\$10 \$20 \$30 Other _____

Include me on your mailing list

E-mail Address: _____

**Make Checks payable to
The Jamaica Nurses Association of Florida, Inc.
P.O. Box 695177
Miami, FL 33269-0254
www.JamaicaNursesFlorida.org**