

AMERICAN SOCIETY FOR PAIN MANAGEMENT NURSING

GREATER KANSAS CITY CHAPTER Membership Application

New Membership Renewal Membership

Name: _____ Credentials: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home phone: _____ Cell: _____ Work: _____

Email: _____

Education: Diploma _____ A D N _____ BSN _____ MSN _____ PhD _____ DSN _____
Other: _____

Place of employment: _____

Member of National: _____ Yes _____ No * *Must be a member of national to
join the local chapter. Please provide
proof with application.*

Pain management areas of interest: _____

I would like to hear speakers on the topics of: _____

I would be willing to speak to groups on the topics of: _____

**PLEASE MAIL APPLICATION TO: GKCC ASPMN
P.O. BOX 412214
KANSAS CITY, MO 64141-2214**

**** Please include \$25.00 for chapter dues and proof of National American
Society for Pain Management Nursing membership.**