



Organizational Affiliate Membership Application

Organization Name: _____

Organization Abbreviation: _____

Office Phone Number: () _____

E-Mail Address: _____

Contact Name: _____

Contact Address: _____

City _____ State _____ Zip Code _____

Home Phone: () _____

Legislative Contact & Email Address, if different: _____

Practice Contact & Email Address, if different: _____

Please remember to include the organizational affiliate fee of \$500.00 with application, or supply payment information below. Make check payable to the Oklahoma Nurses Association.

Credit Card #: _____/_____/_____/_____ CVV _____ EXP _____/_____

Name on Card: _____

Signature: _____ Date: _____

ONA Office use only

Date Received: _____ Date of Membership: _____

Affiliate Fee (\$500.00) Check #: _____ Amount Paid: _____

Expiration Date: _____ Reinstatement Date: _____