

Membership Application 2009

Please Type or Print Clearly: (Incomplete form will delay the processing of your membership) New
Check Appropriate Box New Address Name Change Facility Change Renewal Reinstatement

Mail to be sent to:

Name: _____ Credentials: _____ Previous Name: _____

Address: _____

City: _____

State/Province: _____ Zip: _____

Phone # Home () _____ Phone # Work () _____

Fax # () _____ E-Mail Address _____

Facility Address:

Name: _____

Address: _____

City/State/Province: _____

Zip: _____

Phone # () _____ Fax # () _____

Check work setting

- Long-Term Care Facility Adult Day Care Service Senior Center
 Retirement Home Assisted Living Center Alzheimer's Dementia Unit
 Sub-Acute Unit Senior Service Center Other _____
 Activity Consultant and/or Educator in the field of activities whose primary focus is on geriatric population.

National Certification None NCCAP NCTRC RMT OT Other _____

(Although you do not have to be Nationally Certified to be a NAAP Member, NAAP strongly encourages and supports the certification process)

Length of Experience: Number of years _____ Full time Part time Volunteer

Education: _____ Advanced Studies: _____

Amount Enclosed:	<input type="checkbox"/>	Active Membership	75.00 (USD)
	<input type="checkbox"/>	Associate Membership	65.00 (USD)
	<input type="checkbox"/>	International Membership(outside U.S.)	65.00 (USD)
	<input type="checkbox"/>	Student Membership	55.00 (USD)
	<input type="checkbox"/>	Supportive Membership	99.00 (USD)

I do not want my name included in the membership list sold.

Credit Card Payment Visa Credit Card # _____
 Master Card Expiration Date: _____
 AMX Signature: _____

Send checks, money orders or credit card to: **NAAP**
PO Box 5530 Phone # (865) 429-0717
Sevierville, TN 37864 Fax # (865) 453-9914
Federal I. D. #36-3253020

For NAAP Office Use Only:

Date Received: _____ Amount Paid: _____ Check # _____

Date Mailed: _____ Membership Number: _____

