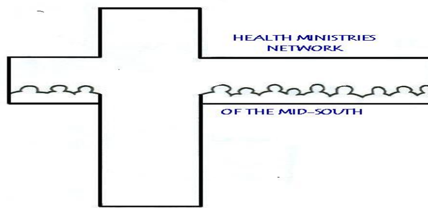

To provide support, networking and continuing education to any nurse involved in parish nursing/health ministries.

Please print and fill out completely

Name ____

Street Address ____

City ___________________________ State______________ Zip ____________________

Home Phone____________________ Work Phone__________________________________

Fax___________________________ Email____

Faith Community ____

Basic Nursing Education: ________________ Graduate Nursing _____________________

Certifications: RN License: ____

Present Employer ________________ Position ___________________________________

Are you currently trained as a Parish Nurse? YES NO
If so, did you complete the Basic preparation Course for Parish Nurse?
When: _____________________ Where: ____

Are you currently working as a Parish Nurse? YES NO
Paid Volunteer Other ____

Type of membership (please check)
____ Full (RN, LPN) $20.00
___ Student (graduate/undergraduate) $15.00

For office use only:
Date_______________
Check number_______
Paid through _______

Please indicate your interests in serving on committees, and any ideas, suggestions, needs:

____

____

I verify that the above information is correct.

Signature____ Date__________________

Please make checks payable to: Parish Nurse Network
Mail to: Membership HMNMS
Community Health Ministry
The Catholic Center
5825 Shelby Oaks Dr.
Memphis, TN 38134