

Member Information **\$250 Organization** **\$50 Individual** *(student, retiree, or single person consulting company)*

Healthcare Organization/School of Nursing _____

Type of Organization _____

Address _____

City, State, Zip, County _____

Please check one: Business Address Home Address

Designated Voting Member

Name & Credentials _____

Title _____

Department/Specialty _____

Mailing address (if different from above) _____

Phone _____ Fax _____

E-mail _____

Additional Representatives from your Organization (Maximum 3)

Representatives may attend all NEONI quarterly meetings and join NEONI Committees. In the absence of the designated voting member, one representative may cast a vote on behalf of the member institution. **Please list representatives in order of voting rights.**

1. Name & Credentials _____

Title _____ E-mail _____

Phone _____ Fax _____

2. Name & Credentials _____

Title _____ E-mail _____

Phone _____ Fax _____

3. Name & Credentials _____

Title _____ E-mail _____

Phone _____ Fax _____

Please send completed form with check payable to *The Center for Health Affairs* to:

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