



# Nevada Public Health Association Membership Application & Renewal Form

\_\_\_\_\_  
*First Name* *Last Name*

\_\_\_\_\_  
*Street Address*

\_\_\_\_\_  
*City* *State* *Zip*

\_\_\_\_\_  
*Employer/Affiliation*

\_\_\_\_\_  
*Degrees/Credentials*

\_\_\_\_\_  
*Email*

\_\_\_\_\_  
*Alternate Email*

\_\_\_\_\_  
*Phone*

\_\_\_\_\_  
*Alternate Phone*

\_\_\_\_\_  
*Fax*

*Are you currently a member of the American Public Health Association (APHA)*

**Yes** **No**

*If yes, what is your membership expiration date* \_\_\_\_\_

.....  
*Please check one*

*Please enclose annual dues*

**New Member**

**Professional - \$30.00**

**Renewal**

**Student - \$15.00**

***Please make check payable to: NPHA***

***Mail form & dues to:***

**NPHA  
PO Box 8543  
Reno, NV 89507**

**[www.nphaonline.org](http://www.nphaonline.org)**

***For NPHA Use:***

Date Received \_\_\_\_\_

Check Received \_\_\_\_\_ (*initial*)

Date Entered \_\_\_\_\_

Entered by \_\_\_\_\_ (*initial*)