



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 _____

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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

<i>For NPHA Use:</i>	
Date Received _____	Check Received _____ (<i>initial</i>)
Date Entered _____	Entered by _____ (<i>initial</i>)