

**AFRICAN NURSES ASSOCIATION
JACKSONVILLE CHAPTER
{AFNA}**

Membership Application

Name: _____ Title: _____

Home Address: _____

Home Phone: _____

Place of Work: _____

Work Address: _____

Work Phone: _____

E-Mail Address: _____

Student: _____ School Name: _____ Graduation Date _____

One time membership fee of \$ 5.00

Dues are \$50.00 per year for local chapter membership, due each
December.

MAIL TO:

AFRICAN NURSES ASSOCIATION
14050 CRESTWICK DRIVE WEST
JACKSONVILLE FL. 32218.