



AMERICAN ASSOCIATION OF
LEGAL NURSE CONSULTANTS

Fax or mail your completed application and payment to:
American Association of Legal Nurse Consultants
1027 Paysphere Circle
Chicago, IL 60674-1027
Phone: 312/321-5177
Fax: 312/673-6655
or join online at www.aalnc.org

MEMBERSHIP APPLICATION

GENERAL INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Credentials (e.g., BSN RN LNCC): _____

Preferred Mailing Address:* Business Home

Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Preferred Telephone:* Business Home

Home Phone: _____ Fax Number: _____ Business Phone: _____

E-mail address: _____ Web-site: _____

* Please circle one to indicate where you prefer to receive mail and be contacted via phone. Note: If your home address is preferred, a company name **will not** appear in any directories published by AALNC.

MEMBERSHIP

Membership Category (select one)

Active \$145

A Registered Nurse maintaining an active license in the US or its territories, who is working in a consulting capacity in the legal field.

Associate \$145

A Registered Nurse maintaining an active license in the US or its territories who is interested in the goals and activities of AALNC, but has NOT worked in a consulting capacity during the previous 12 months.

Sustaining \$225

An individual who practices law or any other individual, business, organization or facility with an interest in the goals and activities of AALNC.

Active and Associate members must provide their RN License Number. Failure to do so will delay the processing of this application.

RN License # _____ State _____ Exp. Date _____

LNC Locator®

Included with your AALNC membership is a listing on the LNC Locator. The LNC Locator is an easy and convenient way for attorneys to locate an LNC or nurse expert witness for their litigation team.

If you prefer not to participate in this program, please check the box below.

I do not want to participate in the LNC Locator program.

LOCAL AFFILIATION

Listed below are the regions and cities in which AALNC is represented by local chapters. Select the chapter you may be interested in joining at a local level.

***If you are interested in joining your local chapter, you will need to contact them directly. Visit www.aalnc.org for information on local chapters.**

Birmingham, AL

Little Rock, AR

Phoenix, AZ

San Francisco, CA

Los Angeles, CA

Orange County, CA

Sacramento, CA

San Diego, CA

Denver, CO

Northern Delaware

Jacksonville, FL

Orlando, FL

Southern Florida

Tampa Bay, FL

Atlanta, GA

Augusta, GA

Chicago, IL

Indianapolis, IN

Lexington, KY

Louisville, KY

Shreveport-Bossier, LA

Southern New
England Area

Baltimore, MD

Detroit, MI

Minneapolis, MN

Saint Louis, MO

Jackson, MS / New
Orleans, LA

Helena, MT

Charlotte, NC

Eastern North Carolina

Western North
Carolina

Morristown, NJ

Albuquerque, NM

New York City, NY

Rochester, NY

Cleveland, OH

Oklahoma City, OK

Portland, OR

Philadelphia, PA

Pittsburgh, PA

Columbia, SC

Nashville, TN

Austin, TX

Dallas, TX

Fort Worth, TX

Houston, TX

Central Virginia

Puget Sound, WA

Southern West Virginia

Casper, WY

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PROFESSIONAL INFORMATION

Clinical Nursing Experience/Area of Practice (Select no more than five. **If expert witness, check box and circle area of expertise.**)

- | | | |
|--|--|---|
| <input type="checkbox"/> ADM Administration | <input type="checkbox"/> HI Head Injury | <input type="checkbox"/> PACU Post Anesthesia Care Unit/ Recovery Room |
| <input type="checkbox"/> AMB Ambulatory Care/Outpatient | <input type="checkbox"/> ICU Intensive Care | <input type="checkbox"/> PAIN Pain/Stress Management |
| <input type="checkbox"/> BDG Birth Defects/Developmental Disabilities/Genetics | <input type="checkbox"/> INF Infection Control/AIDS/Public Health/Epidemiology | <input type="checkbox"/> PED Pediatric |
| <input type="checkbox"/> BN Burn | <input type="checkbox"/> IV Intravenous Therapy | <input type="checkbox"/> PHR Pharmacology |
| <input type="checkbox"/> BRA Brain Injury | <input type="checkbox"/> LD Labor & Delivery | <input type="checkbox"/> PLS Plastic Surgery |
| <input type="checkbox"/> CHN Community Health | <input type="checkbox"/> MS Medical Surgical | <input type="checkbox"/> PSY Psychiatric/Mental Health/ Chemical Dependency |
| <input type="checkbox"/> COR Correctional | <input type="checkbox"/> NA Nurse Anesthetist | <input type="checkbox"/> PUL Pulmonary |
| <input type="checkbox"/> CS Clinical Specialist | <input type="checkbox"/> NEP Nephrology | <input type="checkbox"/> QA Quality Assurance/Assessment |
| <input type="checkbox"/> CV Cardiovascular | <input type="checkbox"/> NEU Neurology | <input type="checkbox"/> RAD Radiology |
| <input type="checkbox"/> DB Diabetes/Nutrition | <input type="checkbox"/> NM Nurse Midwife | <input type="checkbox"/> RHB Rehabilitation |
| <input type="checkbox"/> ED Education | <input type="checkbox"/> NN Neonatal/Newborn | <input type="checkbox"/> RM Risk Management |
| <input type="checkbox"/> END Endoscopy/Enterostomy | <input type="checkbox"/> NP Nurse Practitioner | <input type="checkbox"/> SCI Spinal Cord Injury |
| <input type="checkbox"/> ENT Ear Nose & Throat/Otolaryngology | <input type="checkbox"/> NR Nursing Research | <input type="checkbox"/> SN School/Camp Nursing |
| <input type="checkbox"/> ER Emergency/Trauma | <input type="checkbox"/> NS Nursing Standards | <input type="checkbox"/> SS State Medical Survey |
| <input type="checkbox"/> FLN Flight Nursing/Paramedic | <input type="checkbox"/> OB Obstetrics | <input type="checkbox"/> TR Transplant |
| <input type="checkbox"/> FOR Forensic Nursing/Sexual Assault | <input type="checkbox"/> OFF Office | <input type="checkbox"/> TT Telephone Triage |
| <input type="checkbox"/> FS Federal Medical Survey | <input type="checkbox"/> OH Occupational Health | <input type="checkbox"/> UR Utilization Review/Discharge |
| <input type="checkbox"/> GER Gerontology/Nursing Home | <input type="checkbox"/> ONC Oncology | <input type="checkbox"/> URO Urology |
| <input type="checkbox"/> GI Gastroenterology | <input type="checkbox"/> OPH Ophthalmology | <input type="checkbox"/> WC Wound Care |
| <input type="checkbox"/> GN General Nursing Practice | <input type="checkbox"/> OR Operating Room/Surgery | <input type="checkbox"/> OTH Other |
| <input type="checkbox"/> GYN Gynecology | <input type="checkbox"/> ORT Orthopedics/Sports Medicine | |
| <input type="checkbox"/> HH Home Health | <input type="checkbox"/> PA Physician Assistant | |

Medical/Legal Practice Area (Select no more than six)

- | | | |
|---|--|--|
| <input type="checkbox"/> AHC Administrative Health Care Law | <input type="checkbox"/> LCP Life Care Planning | <input type="checkbox"/> PLP Product Liability, Plaintiff |
| <input type="checkbox"/> BAR Billing Audit Review | <input type="checkbox"/> MMD Medical Malpractice, Defense | <input type="checkbox"/> PLPD Product Liability, Plaintiff/Defense |
| <input type="checkbox"/> CA Case Management | <input type="checkbox"/> MMP Medical Malpractice, Plaintiff | <input type="checkbox"/> PP Post-Partum |
| <input type="checkbox"/> CH Child Abuse | <input type="checkbox"/> MMPD Medical Malpractice, Plaintiff/Defense | <input type="checkbox"/> RHB Rehabilitation |
| <input type="checkbox"/> CM Criminal | <input type="checkbox"/> PID Personal Injury, Defense | <input type="checkbox"/> RM Risk Management |
| <input type="checkbox"/> EL Elder Law | <input type="checkbox"/> PIP Personal Injury, Plaintiff | <input type="checkbox"/> TT Toxic Torts |
| <input type="checkbox"/> EXW Expert Witness | <input type="checkbox"/> PIPD Personal Injury, Plaintiff/Defense | <input type="checkbox"/> WC Workers' Compensation |
| <input type="checkbox"/> IME Independent Medical Examinations | <input type="checkbox"/> PLD Product Liability, Defense | <input type="checkbox"/> OTH Other _____ |

Medical/Legal Practice Setting (Select no more than three)

- | | | |
|--|---|--|
| <input type="checkbox"/> BI Business/Industry | <input type="checkbox"/> HMO Health Management Organization | <input type="checkbox"/> INS Insurance Company |
| <input type="checkbox"/> CF Consulting Firm | <input type="checkbox"/> HSP Hospital | <input type="checkbox"/> LF Law Firm |
| <input type="checkbox"/> GOV Government Agency | <input type="checkbox"/> IND Independent Practice | <input type="checkbox"/> OTH Other _____ |

COMMUNICATIONS

Yes, I will accept facsimile, e-mail and telephone communications. By checking this box, and with my signature below, I consent to receive facsimile, e-mail, and telephone communications by, or on behalf of, AALNC, its local chapters and certification board.

Signature _____

I certify that this application was reviewed by me, and that all entries and information are true and complete to the best of my knowledge.

Signature _____ Date _____

METHOD OF PAYMENT

Check or Money Order Enclosed (Payable in U.S. Funds to AALNC) MasterCard Visa American Express

Amount \$ _____

Card # _____ Exp. Date _____

Cardholder's Name (please print) _____

Signature _____

Membership is valid for one year upon payment. Dues are non-refundable and non-transferable.

Payment of dues is not tax deductible as charitable contributions for income tax purposes, but may be deducted as a business expense. Please consult your tax advisor.