

ASSOCIATION OF PEDIATRIC GASTROENTEROLOGY AND NUTRITION NURSES

MEMBERSHIP APPLICATION

Name _____

Title _____

Place of Employment _____

Address _____

Home Address _____

Telephone (W) _____ Fax _____ (H) _____

E-Mail Address: _____

Nursing Education _____

Year Graduated _____

Graduate Education _____

Year Graduated _____

Highest Degree Held _____

Pediatric Nursing Experience _____

Research Experience _____

Membership in other GI Societies:

Applying for: Full Membership [] Associate Membership []

Area of expertise: _____

Please indicate if you are interested in participating in an APGNN subcommittee:

Program Committee [] Membership Committee []
Professional Development Committee [] Newsletter Committee []
Patient & Family Education [] Nominating Committee []
Research & Publication []
How did you learn about APGNN? _____

Send your application with:

(1.) Signature below from reference or sponsoring letter from a APGNN full member or Gastroenterology/Nutrition Supervisor (2) Annual Dues are \$50.00

Mail to: Carolyn V. Daigneau RN-CS PNP
Baylor College of Medicine/Texas Children's Hospital
Clinical Care Center
MC 1010.00
6621 Fannin
Houston, TX 77030

Questions: Email: cvdaigne@texaschildrenshospital.org

I would like to recommend _____ for membership in APGNN

Signature

PRINT Name