

AMERICAN ASSOCIATION OF LEGAL NURSE CONSULTANTS
Morristown New Jersey Chapter of the AALNC

Application for Chapter Membership

Contact Information

Last Name: _____ First Name: _____ MI: _____

Business Name: _____

Business Address: _____

Business Phone: _____ Business Fax: _____

Email: _____

Home Address: _____

Home City/State/Zip: _____

Home Phone: _____

Preferred Mailing: Home _____ Business _____

RN License #: _____ State Issued: _____ Exp Date: _____

Practice: Independent _____ In-House Law Firm _____ Other _____

Highest Level of Education: _____

Certification (Full Title): _____

Type of Membership

Active: \$50.00 _____ Must be an RN who currently provides consultation on healthcare issues within the legal arena. Active members may vote, hold office, serve on committees and partake of all other benefits of membership. An active member must be a member of the AALNC. Please provide AALNC ID#: _____

Associate: \$40.00 _____ Must be an RN with an interest in legal issues.

Sustaining: \$100.00 _____ Membership granted to individuals or groups with an interest in the goals and activities of the Association.

Method of Payment: Check _____ Money Order _____

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Medical-Legal Practice Area (select no more than six):

- | | |
|---|--|
| <input type="checkbox"/> AHC Adm. Health Care Law | <input type="checkbox"/> MMD Med Mal Defense |
| <input type="checkbox"/> CA Case Management | <input type="checkbox"/> MMP Med Mal Plaintiff |
| <input type="checkbox"/> CM Criminal | <input type="checkbox"/> PID Personal Injury Defense |
| <input type="checkbox"/> EL Elder Law | <input type="checkbox"/> PIP Personal Injury Plaintiff |
| <input type="checkbox"/> EXW Expert Witness | <input type="checkbox"/> PIPD Plaintiff and Defense |
| <input type="checkbox"/> LCP Life Care Planning | <input type="checkbox"/> PLD Product Liability Defense |
| <input type="checkbox"/> Rehabilitation | <input type="checkbox"/> PLP Product Liability Plaintiff |
| <input type="checkbox"/> RM Risk Management | <input type="checkbox"/> Plaintiff and Defense |
| <input type="checkbox"/> IT Toxic Torts | <input type="checkbox"/> WC Worker's Comp |

Clinical Nursing Experience/Area of Practice:

Please list your nursing experience. If you are an expert witness in a particular area, please indicate.

1. _____
2. _____
3. _____
4. _____
5. _____

Committee Interests (for Active Members only):

- | | | |
|---------------------------------------|--|----------------------------------|
| <input type="checkbox"/> Membership | <input type="checkbox"/> Bylaws | <input type="checkbox"/> Finance |
| <input type="checkbox"/> Nominating | <input type="checkbox"/> Publicity / Marketing | |
| <input type="checkbox"/> Publications | <input type="checkbox"/> Education | |

Authorization & Agreement/Verification

I authorize publication of information contained within this application in the NJAALNC Membership Directory.

Signature Date

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