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**NCRN SINGLE MEMBERSHIP DUES FORM FOR 2007-2008**  
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**NCRN Member**

Name of Nursing Center: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/ZIP: \_\_\_\_\_

Name of Academic Institution: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/ZIP: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Email: \_\_\_\_\_

Phone Number: \_\_\_\_\_ FAX Number: \_\_\_\_\_

Please check (✓) which category applies:

<u>Center's Operating Budget</u>	<u>NCRN Annual Dues</u>
_____ \$249,000 or less	\$500.00
_____ \$250,000 to \$499,999	\$750.00
_____ \$500,000 and above	\$1000.00
_____ Associate Member (Individuals, organizations, businesses, government agencies, and others with interest but no centers)	\$50.00

*Please make check payable to: **University of Wisconsin-Milwaukee***

*Return this completed invoice with your payment to:*

Jennifer Weinzierl  
University of Wisconsin-Milwaukee  
College of Nursing  
PO Box 413

Milwaukee, WI 53201-0413