MONTEREY COUNTY REGISTERED NURSES' ASSOCIATION

MEMBERSHIP FORM

I, _____, voluntarily request to join MCRNA as a dues paying member. I understand and authorize Monterey County to deduct membership dues in the amount of $60.00/month.

_____ _____

Signature Date

_____

Employee number

Mailing address:

_____ _____

Work email address

_____ _____

Personal email address

_____ _____

Phone number

Our Mission:

The association is committed to achieving the highest standards of professional nursing and quality patient care.

www.mcrna.com

info@mcrna.com

MCRNA

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Salinas, CA 93905