

Amt. Recd. \$_____

Check # _____

2022 APPLICATION FOR MEMBERSHIP
in the
KANSAS ORGANIZATION OF SKILLED CARE PROFESSIONALS

New Membership

Renewal

I hereby apply for membership in KOSCP and certify that I meet the membership requirements.

Membership Eligibility Requirements

Active Full membership, with voting privileges, shall be available to persons who are currently employed by a KHA member institution, either full or part time, and involved in the delivery of skilled care services. Only full members shall be eligible to serve as Officers and Directors of the Kansas Organization of Skilled Care Professionals.

Please type or print clearly.

NAME _____
(Last) (First) (Middle Initial)

TITLE OF POSITION _____

HOSPITAL _____
(Name)

(Street) (City) (Zip Code)

PHONE # _____ E-MAIL ADDRESS _____
(Area Code) (Number)

TYPE OF FACILITY: (Please circle the ones that apply.)

Swing Bed PPS OR CAH Freestanding Skilled Unit Distinct Hospital-Based Skilled Unit

OTHER DEPARTMENTS WITHIN THE HOSPITAL FOR WHICH I AM RESPONSIBLE ARE:

HOME ADDRESS _____
(Street) (City) (Zip Code)

\$50.00 membership fee enclosed. Please make checks payable to the Kansas Organization of Skilled Care Professionals and return application and check to: Kansas Organization of Skilled Care Professionals, 215 SE 8th Ave., Topeka, KS 66603.

Following the initial application, membership fees will be due by Monday, January 31, 2022.

Signature of Applicant

Nursing License Number