

# Registry Renewal Form

Name \_\_\_\_\_

Street \_\_\_\_\_ Apartment \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security Number \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Please indicate if you have had a change of name or address

**Single credentials are \$55.00 per year.**

**Each additional credential acquired from the NAHP has a yearly due of \$25.00.**

**A \$10.00 fee applies to all payment plans.**

Please mark the appropriate choices below:

## Single Credential

Full Active Renewal \$ 55.00

Payment Plan - First of three payments of: \$ 21.67

## Double Credential

Full Active Renewal \$ 80.00

Payment Plan - First of three payments of: \$ 30.00

**Renew Your Membership**

**Online at:**

**<http://store.nahpusa.com>**

## Triple Credential

Full Active Renewal \$ 105.00

Payment Plan - First of three payments of: \$ 38.34

| Method of Payment |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|-------------------|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
|                   | <input type="radio"/> MasterCard <input type="radio"/> Visa   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|                   | <input type="radio"/> Check/MoneyOrder (U.S. funds Only)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Account #         | <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table> |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| /                 | _____   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Expiration Date   | Cardholders Signature   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

## Billing Information

If you are using a credit card with a billing information different from the name and address above please provide the billing information below:

Name \_\_\_\_\_

Street \_\_\_\_\_ Apartment \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Send payments to: National Association for Health Professionals \* P.O. Box 459 \* Gardner, KS 66030  
Or fax (credit card renewals only) to: 1-913-856-6125

Please allow 4 to 6 weeks for processing to be completed upon receipt of payment  
If you have any questions concerning your renewal please call 1-800-444-0839