* I understand this payment does not guarantee approval but is for the review process only. No refunds will be given for non-approval or withdrawal.
* Electronic Signature: An “X” in the box serves as the electronic signature of the individual completing this **Payment Form** and attests to the accuracy of the information provided above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature (or Printed Name Required) *This signature also authorizes credit card payment.* Date

**Fee $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Late Fee $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**TOTAL AMOUNT: $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\*\*A **Payment Form** copy is required - both mailed (if applicable) & electronically. Do not forget to factor in the time it will take for YOUR organization to process payment and send.

**Information below should be connected to the credit card.**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_

*\*\*\* A receipt will be sent to the email address when the card is processed.*

**Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Director or Person completing the payment process.***

**NURSE PLANNER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_**

**Payable: MNF**

**Mail to: 31 Woodgreen Place**

 **Madison, MS 39110**

**Email to:** **kdorr@msnurses.org**

Submissions are processed on a 4-month cycle and ALL **DEADLINES** are the **1st** of the month.

**SUBMISSION DATES: Indicate if the APPROVED PROVIDER is:**

March cycle (submit DECEMBER) **New or Renewal\***

June cycle (submit MARCH)

September cycle (submit JUNE)

December cycle (submit SEPTEMBER)

**\*RENEWAL: A completed application is required, for review, 4 months prior to the end of your current approval status.** It is the responsibility of the Approved Provider Unit to keep track of its expiration and due dates; an updated AP list can be found on the website.

**Application Fees:**

* $2,000 Self-study
* $200 Late Fee

\***A late fee will be applied to the payment if received after the aforementioned deadline.**

**Payment Options: (check one below)**

* Check\*\*: # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Credit Card

Credit Card Type (check one): \_\_ Visa \_\_ MC \_\_Discover \_\_ Am Ex (4 digit CVN#) \_\_\_\_\_\_

Credit Card: # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Payments can be made online at** [**www.msnursesfoundation.com**](http://www.msnursesfoundation.com) **(click donate)**

**Office Use Only:**

 **Days Until Activity: \_\_\_\_\_\_\_\_**

*Mississippi Nurses Foundation is accredited as an approver of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.*

**APPROVED PROVIDER**

**Payment Form**

 **Provider Unit Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Applications will not be considered complete unless payment & form have been received.**