Certified Health Education Specialists' Participation in Professional Associations: Implications for Marketing and Membership

Rosemary Thackeray, Brad L. Neiger, and Kathleen M. Roe

ABSTRACT

A number of health education professional associations exist to advance the profession through research, practice, and professional development. Benefits of individual membership may include continuing education, networking, leadership, professional recognition, advocacy, professional mobility, access to research findings, advances in the profession, service opportunities, and the ability to help shape the future direction of the profession. The purpose of this study was to analyze membership and involvement in professional associations and identify implications for marketing and sustained membership.

The study sample was randomly selected from the National Commission for Health Education Credentialing, Inc. database. The sampling frame was certified health education specialists living in the United States. Statistical analysis was delimited to respondents who were currently employed. Data were collected using an 88-item self-administered questionnaire.

No dominant professional association exists at the national level as evidenced by the finding that together, APHA, SOPHE, and AAHE capture 55% of the national market. The most common reasons for membership in professional associations include: maintaining CHES certification, advancing the profession, and networking. Based on survey findings, health educators must recommit themselves to increased involvement in associations, and professional associations must take a proactive marketing position to strengthen current and future membership.

INTRODUCTION & BACKGROUND

Professional associations are organizations with membership consisting of professionals with similar job responsibilities, who have received comparable educational training, and may possess a professional license or certification. The purpose of each professional association is unique. In general, a major role is to advance the profession through research, practice, and professional development. This includes activities such as setting standards for practice and establishing a code of ethics,[1] providing continuing education opportunities, acting as a common voice for the profession, and being involved in advocacy including writing position papers and resolutions.

For example, the American Nursing Association and the American Association of Occupational Health Nurses are influential in keeping health care issues on the political agenda.[2] Midwifery and obstetrical associations are activists for reducing worldwide maternal mortality. They do this through advocating for women's rights and establishing a standard of obstetrical practice.[3] State affiliates of the American Public Health Association were influential in supporting plans for the Children's Health Insurance Program.[4] These advocacy activities included development of "white papers," interviews with media, and contacting state legislators.

For individuals, benefits of professional association include one or more of the following: opportunities for networking, leadership, continuing education, professional

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recognition, advocacy, service, and shaping the future direction of the field; subscription to professional journals; access to job banks; and reduced registration fees at conferences. Individual membership in a professional association may be considered one indicator of commitment to the profession.[5,6]

Although there are barriers to individual membership and involvement in professional associations, the published, peer-reviewed literature on the topic is limited. Dunleavy[7] suggests that a main reason that physical therapists do not join professional associations is the cost of membership. Among nurses, cost has also been cited as a barrier, along with distance to meetings, lack of activities in their geographic area, and inability to attend meetings.[8,9]

In health education, there are national, regional, and/or state professional associations. Perhaps the most well-known national health education professional associations with the largest membership are the American Public Health Association (APHA) with 3,000 members in the public health education and health promotion section; the Society for Public Health Education (SOPHE) representing 4,000 members; and the American Association for Health Education (AAHE) with 6,300 members. Regional or state association membership may or may not be linked with a national association. For example, members of an APHA state affiliate or a SOPHE chapter need not be members of the national organization. Additionally, there may be other state-level professional associations without national affiliations.

There is a dearth of peer-reviewed literature that describes research related to health educators' membership and involvement in professional associations, and the factors that influence these decisions. It is not known what percentage of health educators belong to national and regional and/or state professional associations. The degree to which members actually are involved with these associations also is not known. The purpose of this paper is to describe a study that examined Certified Health Education Specialists' (CHES) membership and involvement in health education-related professional associations. Implications for marketing and sustained membership and involvement, which are applicable to both practitioners and association leadership, are provided.

METHODS

This was a descriptive, cross-sectional study. The sampling frame was the National Commission for Health Education Credentialing, Inc. (NCHEC) database of all certified health education specialists living within the United States (n=5,718). The CHES certification establishes a "national standard for preparation in health education; attests to the individual's knowledge and skills; and establishes an entry-level standard for employers in identifying qualified health education practitioners."[10] Although not all health educators are CHES certified, the NCHEC list is the broadest available sampling frame of health educators, and it represents a variety of individuals, not just those who are members of one association or organization. Since the inception of the CHES credential in 1989, over 6,000 individuals have become certified.[11]

Researchers used SPSS 12.0 to select a simple random sample (n=800) from the NCHEC list. The sample was calculated based on a cross-sectional descriptive study where the membership proportion was unknown, and a response rate of approximately 70% was expected.[12] Thirty-nine surveys were returned as undeliverable with no forwarding address, two respondents were living out of the country, and one respondent was retired, resulting in a final sample of 758. The response rate was 63.9%, or 485 completed surveys. The statistical analysis was delimited to respondents who indicated they were currently employed (N=416).

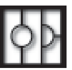
Data were collected using an 88-item self-administered questionnaire. Survey items included the following: current membership (5 items); involvement (20 items); employer support (7 items); reason for membership (1 item); general demographics (12 items); job satisfaction (36 items; data not reported); and 8 questions on miscellaneous professional issues, which were not used. All question response options were nominal or ordinal scales. Twenty-six certified health education specialists who were current SOPHE members were selected to complete a pilot test. The purpose of the pilot test was to establish face validity. Eighteen of 26 surveys were returned for a response rate of 69%.

Questions relating to current membership and involvement in professional associations were developed based on a similar study among dieticians.[13] Membership was assessed by one question that asked whether the respondent was a current member of one of the three largest associations: SOPHE, APHA, AAHE, or a member of another health education-related professional association. A similar question asked about membership in a state or regional association.

Involvement in the association was measured by assessing membership in a special interest group (SOPHE) or section (APHA), whether the respondent had voted in the last association election, if he or she had served as a committee member in the last three years, if he or she had served as an elected officer, if he or she had attended at least one annual meeting or conference in the last three years, or had attended at least one mid-year meeting in the last three years (SOPHE).

Employer support was measured by asking the respondent's perception of how supportive his or her employer was of their involvement in associations, the amount of expenses that were covered for travel to association meetings, and how much of his or her time was paid for participation in association activities.

Researchers followed the Dillman Total Design Method[14] to conduct the survey. Two weeks before the survey was to be mailed, researchers sent potential respondents a postcard indicating they were selected to participate in a research study and they would soon be receiving a survey. Participants then received a copy of the survey and a self-addressed, stamped envelope for return mailing. Researchers coded the survey



return envelope with a unique identifier. This number was developed for tracking purposes only. The envelope was destroyed upon receipt of the survey. A cover letter containing the requisite elements of informed consent accompanied the survey. A returned survey indicated participant consent to participate in the study. All responses remained confidential and there were no data that allowed researchers to link surveys to individual participants. Two weeks after the initial mailing, researchers sent a reminder postcard to all participants who had not returned the survey. Four weeks after the initial mailing, researchers sent a second copy of the survey to all non-respondents.

RESULTS

Table 1 displays the demographics and association membership of survey respondents. Respondents were employed in a variety of settings, with 22.6% coming from a university, followed by "other" (13.9%) (primarily public school or non-profit organization), local government (12.7%), hospital (9.9%), community-based organization (9.9%), and state government (9.1%).

Fifty-five percent of respondents indicated they were members of APHA, SOPHE, or AAHE. Membership was not associated with full-time or part-time employment, gender, race, hours worked per week, or percent of the job that was directly related to health education (Table 1). Membership was associated with the number of years worked in health education, income, highest degree obtained, and age. Examination of standardized residuals revealed that people with more than 20 years of experience, a doctorate degree and income of at least $50,000 were more likely to be members of APHA, SOPHE, or AAHE.

In contrast, membership in a state or regional association was not associated with income, gender, percent of job directly related to health education, full-time versus part-time work, or hours worked per week (data not shown). However, similar to national association membership, state or regional membership was associated with years employed as a health educator (X^2 = 22.27; p = .00), age (X^2 = 9.63; p = .047) and highest degree received (X^2 = 9.262; p = .01).

Results of national association membership and involvement are presented in Table 2. Almost four percent of respondents (3.6%) indicated they were members of all three associations. There were 13.7% who were members of both APHA and SOPHE; 6.2% stated they were members of AAHE and SOPHE or AAHE and APHA. In addition, 173 respondents indicated they were not members of APHA, SOPHE, or AAHE (see Table 1). Of these, 36% indicated they were members of another national professional association. Similarly, 57.1% responded that they were members of a state or regional professional association.

Most respondents felt they were *not involved* or were *involved very little* in national associations (83.5%) and state or regional associations (68.3%). Respondents indicated the primary reason they were involved in professional associations was to maintain CHES certification (37.7%). This was followed by the opportunity to advance the profession (23.8%) and to network (22.8%). Related to involvement in state or regional associations, 47.5% reported serving on a committee, 31.4% stated they had served as an officer, and 83.2% reported that in the last three years they had attended at least one annual conference.

When asked about their employer's support of membership in and involvement with professional associations, respondents revealed the following: Less than half (47.8%) agreed *moderately* or agreed *very much* that their employer was supportive of their involvement in professional associations. When asked if their employer was supportive of their attendance at health education-related professional conferences, over half (53.3%) agreed *moderately* or agreed *very much*. Over half of respondents (55.2%) stated they were *always* paid for time to attend health education-related professional meetings; 24% indicated this happens *sometimes*. When asked about costs associated with attending health education-related annual meetings or conferences, half (51.9%) of respondents said that each year the *full cost* of registration for one conference was paid for; 20.1% stated that *part of the cost* was paid. Less than half (44.5%) said that each year their employer paid the *full costs* of travel, lodging, and meals to attend at least one health education-related professional conference; and 25.2% said *part of the cost* was paid.

DISCUSSION

It is not known what percent of health educators belong to a professional association. However, this study found that among certified health education specialists, membership in professional associations is very impressive. Ninety-one percent of all respondents indicated they were members of at least one national professional association. In contrast, approximately 74% of registered dieticians are members of the American Dietetic Association (Mary Jawgiel, personal communication, January 20, 2004). Among environmental health specialists, it is estimated that 57% are members of a professional association.[15] One-third of doctors are members of the American Medical Association, down from 90% in the 1950s.[16] Only 7% of nurses are members of the American Nurses Association.[17]

However, membership of certified health education specialists in professional associations is fractured. Health educators choose to maintain membership in one, or more, of several associations. Over half of respondents reported membership in APHA, SOPHE, or AAHE. The reported membership in other national professional associations may include: American School Health Association, American Academy for Health Behavior, American College Health Association, Eta Sigma Gamma, and the Association of State and Territorial Directors of Health Promotion and Public Health Education.

In the current study, despite a relatively high percentage of respondents who belong to a national professional association, active participation or involvement in these associations is very low. The low levels of involvement may be attributed to a variety

Table 1. Summary of Demographics and Other Variables by Association Membership

	Member of SOPHE, APHA, or AAHE				$X2$	*P* values
	YES		NO			
	No.	%	No.	%		
Total	217	55.6	173	44.4		
Gender					1.18	.28
Male	26	12.1	15	8.7		
Female	189	87.9	158	91.3		
Age					20.12	.00*
Less than 25	12	5.5	14	8.1		
25–34	74	34.1	85	49.1		
35–44	38	17.5	31	17.9		
45–54	62	28.6	37	21.4		
55+	31	14.3	6	3.5		
Race					1.46	.23
Caucasian	167	78.4	125	73.1		
All Other Races	46	21.6	46	26.9		
Income					18.51	.01*
<19,999	11	5.2	10	5.8		
20–29,999	13	6.2	27	15.7		
30–39,999	44	21.0	51	29.7		
40–49,999	50	23.8	37	21.5		
50–59,999	37	17.6	19	11.0		
60–69,999	24	11.4	13	7.6		
70–79,999	13	6.2	7	4.1		
80,000+	18	8.6	8	4.7		
Employment					.343	.56
Full-Time	193	88.9	157	90.8		
Part-Time	27	11.1	16	9.2		
Hours Worked Per Week					1.820	.61
< 35	26	21	19	11.1		
36–40	77	35.6	67	39.2		
41–50	81	37.5	67	39.2		
50+	32	14.8	18	10.5		
Years Working in Health Education					15.274	.00*
<1	18	8.4	28	16.3		
1–5	75	35.0	73	42.4		
6–10	39	18.2	29	16.9		
11–15	28	13.1	17	9.9		
16–20	21	9.8	15	8.7		
>20	33	15.4	10	5.8		
Percent of Job Related to Health Education					3.142	.53
<25	17	10.2	13	10.8		
25–49	26	15.2	11	9.2		
50–74	32	19.3	21	17.5		
75–99	33	19.9	28	23.3		
100	58	34.9	47	39.2		
Highest Degree Obtained					36.295	.00*
Bachelors	33	15.3	63	36.4		
Masters	138	63.9	102	59.0		
Doctorate	45	20.8	8	4.6		

Note: * Significant at $P = .05$.

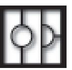


Table 2. Certified Health Education Specialists Membership and Involvement in Health Education-related Professional Associations

Professional Association	Current member	Voted in last election	Served as committee member	Held elected office	Member of section or special interest group	Attended at least one annual meeting in the last 3 years	Attended at least one mid-year meeting in the last 3 years
American Public Health Association	31.3 %	37.8 %	6.6 %	0.8 %	81 %	61.7 %	*
Society for Public Health Education	29.9 %	57.5 %	18.8 %	9.8 %	53.1 %	40.2 %	22.5 %
American Association for Health Education	18.9 %	54.9 %	31 %	11.3 %	*	54.3 %	*

Note: * not applicable. Because respondents could claim membership in more than one of the three associations, percentages are not cumulative and will not total 100%. A total of 52.2% of respondents belonged to one of the three associations listed.

of factors. One of the key barriers may be time. A person's existing job responsibilities most often take priority, leaving little time for outside professional involvement. The lack of employer support, as noted earlier, further exacerbates these challenges. Dues of SOPHE, APHA, and AAHE range from $125 to $160 annually. The average registration cost for associations' annual meetings is $255. Additional travel costs quickly accrue and organizational travel budgets are often inadequate. If an individual must take time off work to attend meetings or to be involved in activities, and has to pay for membership dues, travel to conferences, or conference registration fees, he/she is less likely to be involved. Additionally, the study results reveal that characteristics of those who were not members of a professional association include being young and over-worked. Half of non-members were under than 34 years of age and 59% worked in the field five years or less. Half of them are working more than 40 hours per week.

The lack of involvement in national associations may be due to an unanticipated disconnect between the activities and opportunities that national associations offer and what practicing health educators need and want. It is also possible that the associations have difficulty in effectively facilitating active member involvement in national association projects and priorities.

Health educators are more involved in state or regional associations. This may be due to a variety of reasons. First, annual membership dues or fees are sometimes less at the local level, thereby making the cost of membership more feasible. For example, the Colorado Public Health Association membership fee is $35 per year. The Southern California SOPHE Chapter fee is $40 per year. Second, with fewer members in state or regional associations individuals may feel their contribution is both wanted and needed. The benefits of networking also may be more tangible at the local or regional level, making this appear to be a better investment of time and resources. There also may be more opportunities to serve in leadership capacities. Third, people may see a greater value of involvement locally than nationally. For example, results of efforts to change local public health policy can be more readily apparent, as compared with efforts to change national level policies.

There may be other factors that contribute to low involvement at both the national and state or regional level. For example, professional preparation programs at universities may not adequately emphasize the opportunities that exist for service within the profession, including the existence of professional organizations, and the importance of sustained involvement. Though it would seem intuitive that faculty members already engage in these behaviors, there is no peer-reviewed literature to confirm this.

Additionally, once professional practice begins there appears to be decreased commitment to both scholarship and service among practitioners. The majority of job descriptions for public or community health educators do not include publishing peer-review papers and serving on professional association committees. The exception is for those health educators who enter academia, where clear expectations to publish and present research findings and engage in professional service exist. Membership and involvement in professional associations provides these opportunities.

Three primary reasons identified in this study for professional association membership were to maintain CHES certification, to advance the profession, and to network. The most common motive for membership was to maintain CHES certification. This response may be a reflection of the fact that the sample was selected from health educators who were CHES certified. Nevertheless, the national or state professional association that caters to this market demand most effectively will likely outpace its competitors for sustained membership. To maintain certification, 75 continuing education contact hours (CECH) are required during the 5-year certification period.

These contact hours often are obtained at association-related conferences. A benefit of membership is a reduced registration fee for these conferences. Sometimes the CECH provided at these conferences cost less for association members.

The second most common reason for being part of a professional association was to advance the profession. This rationale fits well with one of the primary purposes of professional associations, which is advocacy. However, few individuals were involved in activities that could result in a meaningful contribution to the profession. For example, among APHA and SOPHE members many reported that, in addition to general membership, they were also members of special interest groups or sections. These smaller subgroups often provide the greatest opportunity to be actively involved in projects or initiatives but are not always mobilized for broader policy or advocacy efforts. Few respondents said that they served on a committee or as an elected official. Serving in these latter capacities provides the opportunity for individuals to make meaningful contributions to advance the profession.

The third response given for membership was opportunities for networking. This may be a manifestation of the fact that many respondents had worked as a health educator for five years or less. Therefore, they may have been attempting to develop their personal and professional network. Conferences and leadership opportunities provide excellent opportunities to meet and develop relationships with professional colleagues. These networks often lead to new ideas, strategies, jobs, partnerships, and research opportunities. It is apparent that both national and state associations should strategize ways to draw young professionals early in their careers to either committees or other assignments to solidify interest in the profession and institutionalize membership in the association. This should be done primarily by promoting a wide range of options for earning continuing education contact hours as well as integrating young professionals in efforts to advance health education as a profession, and by providing opportunities to network with other health educators.

Women compose an overwhelming proportion of the health education profession. The NCHEC database does not collect gender-related information. However, among current SOPHE members, 76% are female and 16% male (8% not specified) (E. Dixon-Terry; written communication; May 11, 2004). In this study, the majority of respondents were women, and primarily younger women. However, among respondents, a greater proportion of men, as compared with women, were members of professional associations. This may be explained by the possibility that women in this age range (under 34 years) may have children and related responsibilities that prevent them from being more actively involved, particularly when the activities are not supported by the employer and must be done outside of regular work hours. Although gender bias is a constant challenge in the workplace, given the demographics presented here, identifying and understanding motivational forces of young professional women and systematically responding to their wants and needs is an area of attention that should be considered by professional associations.

LIMITATIONS

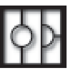
This study included only certified health education specialists, which may be a source of bias, if, in fact, there are differences in professional association membership and involvement among non-certified health education specialists. While the NCHEC database is the broadest sampling frame of health educators available, the degree to which these data can be generalized to all health educators is unclear. Respondents were not asked to identify which national professional associations they were members of beyond APHA, SOPHE, and AAHE. However, these three associations have the largest memberships representing health educators. Finally, although the response rate was 63.9%, additional bias may be the result of respondents being been more likely than non-respondents to be professional association members.

CONCLUSIONS

Traditionally, the purpose of professional associations is to promote health and advance the profession by setting standards of practice or advocating for certification. Although all health educators ultimately benefit from these activities, the authors assert that there may be a disconnect between these goals and what practicing health educators want and need. In order to sustain the existence of these associations and the work they do for the profession as a whole, practicing professionals continue memberships and membership dues. It may be time for national and state or regional associations to re-think their strategies to attract members, and adopt a comprehensive, systematic, planned approach to strengthen both membership and involvement in the associations, and for professionals to re-examine their commitment to the profession. To achieve these aims, the authors provide the following suggestions.

First, health educators must recommit themselves to professional involvement. As noted earlier, membership in an association can be considered an indicator of commitment to the profession.[5,6] There must be a change in the social norm so that being a health educator means not only membership, but being involved in the work of professional associations. This increase in involvement will require health educators to attend professional conferences, make presentations at these conferences, volunteer to serve on committees, run for office, be involved in advocacy, and mentor new professionals. Professionals can also work to increase employer support by articulating the value of professional involvement for both the agency and public health. In turn, associations can recognize an individual's service through certificates, formal thank-you letters, plaques, and awards that can be prominently displayed at the worksite.

Second, in an effort to involve health educators in professional associations early in their careers, university professional preparation programs should encourage student membership and involvement. Professors can serve as role models and articulate the



importance of involvement. Most professional associations have student rates for membership. In addition, they provide students with opportunities to serve, to earn scholarships, and to network. Professional associations may also consider the development of student chapters, which could serve as conduits to continued professional involvement. Creating loyalty among students and getting students involved at the start of their careers may solidify their involvement throughout their professional careers.

Further, professional associations could promote membership by reaching out to all incoming health education students and graduating cohorts. SOPHE's *Academic Anchors* program could serve as a model. *Academic Anchors* are SOPHE members in colleges and universities who recruit and introduce students to SOPHE, then mentor them through introductory phases of membership. This may involve something as simple as providing membership applications to students or discussing member benefits as outlined on the association's website. It may also include accompanying students to conferences, introducing them to SOPHE members who may provide access to internship or employment opportunities, or engaging student members in the work of the association.

Third, associations can make it easier for professionals to become involved. For example, volunteer recruitment can emphasize that it is relatively inexpensive to participate on a committee or serve as an elected official in a national association because communication and tasks are completed via email and telephone conference calls. Associations can also post minutes of committee meetings and working groups on websites, and establish listservs or discussion groups for networking. These efforts would demonstrate to interested members the productivity and accessibility of committees, working groups and the association in general. Associations could structure all committees with members who have a range of experience and make a concerted effort to reach out to new and potential leaders. Networking both within and across intergenerational levels might better engage the range of experiences in the field.

Fourth, associations may consider incorporating career development into association activities. Associations must help health educators understand how association membership and involvement can help them achieve their career goals. Currently, opportunities for involvement emphasize advancing the profession, topical updates, service, and scholarship. To maintain involvement of professionals, a parallel commitment to working groups, discussion of career development, and skill training for different levels of practice and experience may be warranted. Associations could provide career development opportunities such as the *Public Health Education Leadership Institute* sponsored by SOPHE and the Association of State and Territorial Directors of Public Health Education.

Associations could also enhance efforts to further recognize the accomplishments of individuals in mid-career. Associations do well at recognizing and encouraging students and even "new professionals," but after that there is not much recognition or articulated support until one is eligible for lifetime contribution awards such as the SOPHE *Distinguished Fellow*. "Developmental milestone" recognitions should be considered as a way to support and encourage mid-career professionals. Examples include the APHA Public Health Education and Health Promotion *Early Career Award* and the AAHE *Horizon Award*, both of which are granted to professionals with 10 or fewer years of experience.

Fifth, professional associations must also take the initiative and accept responsibility to continue to market themselves. Because professional associations function in a competitive market economy, and health educators must choose which association to support, associations must do a better job of reaching out to members, engaging them in professional causes and establishing brand, or association, loyalty. Before individuals are willing to invest a significant amount of time and money they must clearly recognize the benefits of membership. Associations may want to consider allowing members to have exclusive access to job announcements or job banks, listservs, or allowing members who submit abstracts for annual conferences or meetings to receive priority status for having these accepted for presentation. Some associations offer value-added benefits such as travel and vacation discounts, credit cards, and insurance.[18,19] As long as both members and nonmembers have equal access to benefits such as conferences and journals, and they collectively benefit from the outcomes of advocacy work, health educators may not appreciate the value of membership and the current involvement rates will persist. Association leadership may also consider conducting formative research, using a theoretical framework, with current members and prospective members to better understand the perceived barriers and benefits to association membership and involvement.

Professional associations are only as strong as their leadership and membership. The future success of health education is dependent, in part, on professional associations continuing to serve as a voice for health education. To do so, health educators, including those who serve in association leadership, must be proactive to develop a comprehensive, systematic process that ensures sustained membership growth.

REFERENCES

1. Dollinger ML. Professional associations: ethics, duty and power. *J New York State Nurs Assoc*. 2000;31(2):28–30.

2. Ennen KA. Shaping the future of practice through political activity: how nurses can influence health care policy. *AAOHN J*. 2001;49(12):557–570.

3. Chamberlain J, McDonagh R, Lalonde A, et al. The role of professional associations in reducing maternal mortality worldwide. *Int J Gynaecol Obstet*. 2003;83(1):94–102.

4. Affiliates rally to support state Children's Health Insurance Program plans. *Nations Health*. October, 1998:7.

5. Taub A. One voice for health education: Can this be achieved? *Health Educ Q*. 1985;12(4):293–301.

6. Blau G. Early-career job factors influencing the professional commitment of medical technologists. *Academy of Management J.* 1999;42(6): 687–695.

7. Dunleavy JM. Professionalism and association membership. *PTmagazine*. 2001;9(7): 18–19.

8. DeLeskey K. Factors affecting nurses' decision to maintain membership in professional associations. *J PeriAnesthesia Nurs*. 2003; 18(1):8–17.

9. Yeager SJ, Kline M. Professional association membership of nurse: factors affecting membership and the decision to join an association. *Res Nurs Health*. 1983;6:45–52.

10. National Commission for Health Education Credentialing. Why Certify? Available at: www.nchec.org/whycert/certify.htm. Accessed May 23, 2005.

11. Allegrante JP, Moon, RW, Auld ME, et al. Continuing education needs of the currently employed public health education workforce. *Am J Public Health*. 2001;91(8):1230–1234.

12. Lemeshow S, Hosmer DW, Klar J, Lwanga SK. *Adequacy of Sample Size in Health Studies*. New York: Wiley; 1990. Cited by: Aday L. *Designing and Conducting Health Surveys. 2nd Ed.* San Francisco: Jossey Bass; 1996.

13. Mortensen JK, Nyland NK, Fullmer S, et al. Professional involvement is associated with increased job satisfaction among dietitians. *J Am Diet Assoc*. 2002;102:1452–1454.

14. Bernard HR. *Social Research Methods. Qualitative and Quantitative Approaches*. Thousand Oaks, CA: Sage Publications; 2000.

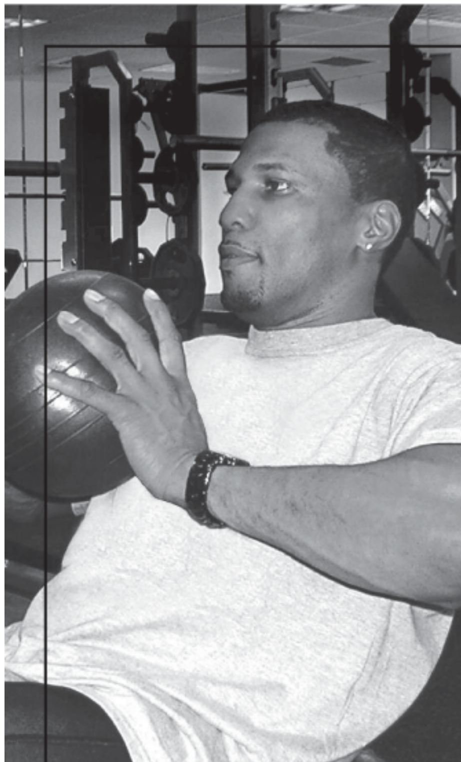
15. Oleckno WA, Blacconiere MJ. Job Satisfaction Among Environmental Health Professionals: An examination of descriptors, correlates and predictors. *J Environ Health*. 1993;55:10–15.

16. Romano M. The great unifier? *Modern Healthcare*. 2001;31(23):24–25.

17. Foley ME. ANA: Preserving the core while preparing the future. *The Am Nurse*. 2001;33(2):5.

18. American Nurses Association. Member Benefits and Discounts. Available at: http://www.ana.org/member2.htm. Accessed March 4, 2005.

19. American Dietetic Association. Your Roadmap to Professional Achievement. Available at: http://www.eatright.org. Accessed March 4, 2005.



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