National HCP Coalition

Membership Application Form

☐ New ☐ Renewal

Applicant Information

Name: _____ Date: _____
Last *First*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email _____

Organization: _____

Please describe your involvement with HCPs and/or the Coalition (optional): _____

_____

_____

Membership Categories

Please select a membership category;

Patron	$5,000.00 and above	_____
Champion	$2,500.00	_____
Sustaining	$1,000.00	_____
Sponsor	$500.00	_____
Agency	$250.00	_____
Individual	$100.00	_____

Send Application to ieh@cal.net

Note: Upon acceptance and processing of the membership application, an invoice will be sent to you/your agency.

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