



Membership Application Form

Name: _____ Date: _____

Place of Employment: _____

Job Title: _____

Mailing Address: _____

City _____ State _____ ZIP+ 4 _____

Telephone (____)____-____ Fax (____)____-____ Email _____

Home phone (____)____-____ List Serve ___Yes ___No

Member Category: ___ Individual ___ Organization ___ Student

Organization: Names of additional members: _____ E-Mail Addresses _____

- 1.
- 2.

Membership Fees:

Individual	\$50.00	(includes 1 voting membership)
Organization:	\$400.00	(includes 3 voting memberships)
Student:	\$10.00	(Non-voting)

Dues are payable on or before January 1 for the calendar year.

Make payment to: **Arizona School-Based/School-Linked Health Care Council**
 Mail application & payment to: **Bonnie Gance-Cleveland, Treasurer, AZ School-Based Health Care Council, 2920 N. 24th Ave., Ste.250, Phoenix, AZ 85015**

I would like to help on the following committee(s):

Advocacy ___ Data ___ Grant writing ___
 Nominations ___ Program ___ Standards ___ Membership ___