



**ARIZONA SCHOOL-BASED HEALTH CARE COUNCIL, INC
MEMBERSHIP**

Name: _____ Date: _____

Title: _____

Employer: _____

Mailing Address: _____

City: _____ State : _____ Zip: _____

Phone: _____ E-Mail: _____

Cell #: _____

Member Category:

_____ Individual - \$50.00

_____ Organization - \$400 (Includes 3 voting memberships)

Additional Member Name: _____

Email: _____

Additional Member Name: _____

Email: _____

_____ Student - \$10.00 (Non-voting)

\$ _____ Donation (Tax deductible - check with your tax advisor)

\$ _____ **Total**

Make payment to: Arizona School Based Health Care Council, Inc.

Mail to: 202 E. McDowell, #130, Phoenix, AZ 85004-4588

Thank You!

Contact: Ruth Mota, Administrative Assistant

rimota@azshbc.org

