**Organizational Membership Application**

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| **Name of organization:** | | |
| **Street address:** | | |
| **City:** | **County:** | **Zip:** |
| **Phone:** | **Email:** | |
| **Organization’s web address:** | | |
| **Chief executive’s name:** | | |
| **Chief executive’s title:** | | |
| **Phone:** | **Email:** | |
| **Will the chief executive represent your organization on the CAHA Board of Directors?**  **\_\_ Yes \_\_ No**  **If no, please list below your organization’s representative (must be an employee in a decision-making role):** | | |
| **Name:** | **Title:** | |
| **Phone:** | **Email:** | |
| **Type of organization, services and/or programs offered:** | | |
| **Why are you interested in becoming a member of the Capital Area Health Alliance, and how do you see your organization contributing to the Alliance?** | | |
| **What type of membership are you interested in?**  **\_\_ Sustaining Membership**  **\_\_ Sponsoring Membership**  **\_\_ Supporting Membership** | | |
| **Chief executive’s signature:** | **Date:** | |

**Please include the following items with your membership application:**

**• Current list of leadership staff**

**• Most recent annual report**

**• Descriptive brochures**

**Submit application and attachments to the address/email listed below.**