California Central Valley Coalition for Compassionate Care - CCVCCC

☐ **New Membership** ☐ **Renewal**

1 Membership Category: ☐ Organization - $100 ☐ Individual - $20

2 Contact Information:

First Name: Last Name:

Prof. Designation/Credential(s) – e.g. RN, OT, MSW:

Position/Title: Dept.

Organization:

Address: | City: | Zip:

E-Mail Address:

Work Phone: Work Fax:

Mobile Phone: Home Phone:

(Organization Applicants Only) Please provide contact information

Organization Name :

Contact Person:

Position/Title: Dept.

E-Mail Address:

Work Phone: Work Fax:

Mobile Phone:

Membership Agreement:

As an applicant to the California Central Valley Coalition for Compassionate Care CCVCCC, I/we do affirm to voluntarily abide by and support the goals and objectives of the organization. In addition,

I/we agree
to accept e-mail communications form CCVCCC relative to the business of the organization.

Signature: Print Name:

Work Phone: Work Email:

3 Payment:

____Check: Check #_____________ Make Checks Payable to CCVCCC

____Cash: Amount collected $_______________ Treasure Int________

____Credit Card: Visa, MasterCard only please

Card Number____Exp_________________________3-digit code__________

Total Enclosed: ☐

Membership effective Jan 1st – Dec 31th annually **EIN # 47-1477948**