Cape & Islands Suicide Prevention Coalition

awareness • education • action

CAPE AND ISLANDS SUICIDE PREVENTION MEMBERSHIP FORM

Name: _____

Org./Agency/Company (if applicable): _____

Mailing Address: _____

Town: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Organization/Agency mission: (if applicable) _____

_____

Do you want to receive notification of meetings and events by e-mail? Yes No

Do you want your information to be listed in the Coalition's On Line Member Directory?
Yes No

What working group(s) are you currently involved in? _____

If you are not on a working group, what working group(s) are you interested in joining?
Please circle.

Events Fundraising Training

☐ I grant permission to the Cape & Islands Suicide Prevention Coalition to share my contact information with the Massachusetts Coalition for Suicide Prevention.

☐ I am a person with a disability and require the following accommodation(s) to participate at Coalition meetings: _____

_____