PROVIDERS' COUNCIL

Envisioning change • Leading advocacy • Driving progress

ASSOCIATE MEMBERSHIP APPLICATION

Company/Organization Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone: (___) _____ - _____ Fax: (___) _____ - _____

Primary Contact:_____ Job title:_____

Email:_____ Website: http://_____

Would you like a link to your website posted on ours (www.providers.org)? ❑Yes ❑ No

Additional contacts: *(please let us know if anyone else at your organization would benefit from our information about marketing opportunities or human service news)*

Name:_____ Name:_____

Title:_____ Title:_____

Email:_____ Email:_____

Associate Membership dues:
$500

How did you find out about Providers' Council? _____

_____

Why are you joining the Providers' Council? _____

_____

Please make checks payable to MCHSP, Inc.
Mail to: 88 Broad St., 5th Floor, Boston, MA 02110.

Note: Dues are not a deductible as a charitable contribution.
Membership lasts for the calendar year: January through December

Questions? Contact Christina Broughton at christina@providers.org or 617.428.3637 x125