



## 2022 ASSOCIATE MEMBERSHIP

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](http://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

Please make checks payable to MCHSP, Inc.  
 Mail to: 100 Crossing Blvd., Suite 100, Framingham, MA 01702.

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

**Questions?** Contact [info@providers.org](mailto:info@providers.org) or 508.598.9800.