NATIONAL ASSOCIATION OF Community Health Centers

Associate Membership Application

Associate Membership: This category is a non-voting category of membership, open to any non-profit primary health care organization which is committed to the mission and goals of NACHC, and which does not meet the criteria for Organizational Membership.

Annual Dues: $750.00

SECTION 1. ORGANIZATION INFORMATION (PRINT CLEARLY)

Name of Organization

Key Contact

Title

Address

City **State** **Zip Code**

Telephone **Fax** **E-mail**

Organization Website **Social Media Handle:** ☐ **Facebook** ☐ **Twitter** ☐ **Instagram** ☐ **LinkedIn**

Three EASY ways to apply:

MAIL
Mail application and payment to:
NACHC Membership Department
7501 Wisconsin Avenue, 1100W
Bethesda, MD 20814

E-MAIL
E-mail application form with credit card information to: **membership@nachc.org**

FAX
Fax application form with credit card information to: **(301) 347-0459**

Sign up as a **NACHC Health Center Advocate** on www.hcadvocacy.org and receive relevant advocacy and policy communications.

☐ Register me as a NACHC Health Center Advocate!

☐ Yes, I would like to receive the one free annual subscription to *Community Health Forum* magazine, unless I advise differently.

SECTION 2. PAYMENT INFORMATION (Payment *MUST* be received with application)

☐ Check is enclosed payable to NACHC **TOTAL PAYMENT ENCLOSED: $_____**

☐ I authorize NACHC to charge my credit card Select One: ☐ MasterCard ☐ Visa ☐ American Express

Name as it appears on card (Please Print)

Credit Card Number **Expiration Date**

Card Holder's Signature **Date**