

New Membership Renewal

1 Membership Category: Individual - \$20 Organization (up to 4 voting members) - \$100

2 Contact Information:

First Name: _____ Last Name: _____
Prof. Designation/Credential(s) – e.g. RN, OT, MSN: _____
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 for up to 3 additional employees:

First Name 2: _____ Last Name 2: _____
Prof. Designation/Credential(s) – e.g. RN, OT, MSN: _____
Position/Title: _____ Dept. _____
E-Mail Address: _____
Work Phone: _____ Work Fax: _____
Mobile Phone: _____ Home Phone: _____

First Name 3: _____ Last Name 3: _____
Prof. Designation/Credential(s)/Degree(s) – e.g. RN, OT, MSN: _____
Position/Title: _____ Dept. _____
E-Mail Address: _____
Work Phone: _____ Work Fax: _____
Mobile Phone: _____ Home Phone: _____

First Name 4: _____ Last Name 4: _____
Prof. Designation/Credential(s)/Degree(s) – e.g. RN, OT, MSN: _____
Position/Title: _____ Dept. _____
E-Mail Address: _____
Work Phone: _____ Work Fax: _____
Mobile Phone: _____ Home Phone: _____

3 Membership Agreement:

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

Signature: _____ Print Name: _____ Date: _____

4 Payment:

Please make check payable to **"Optimal Hospice Foundation - CCVCCC"** and return with form to:
CCVCCC c/o Amdal In-Home Care, 4848 N. First Street #104, Fresno, CA 93726 Questions? Call 559.723.9378

Total Enclosed: _____ **Membership effective July 1st – June 30th each year**