



# FLORIDA HOSPICES AND PALLIATIVE CARE

## MEMBERSHIP APPLICATION

### PATRON Associate Member

Florida Hospices and Palliative Care (FHPC) invites you to renew your Associate Membership for 2011. Your dollars contribute to our community based and directed hospice programs that provide so many extra services to their communities. Please complete and return this application and we will begin processing your membership. This application can be mailed, faxed, or e-mailed to our office based on your preferred method of payment.

EACH APPLICANT IS REQUIRED TO COMPLETE THIS FORM IN ITS ENTIRETY. IF NECESSARY, PLEASE USE "N/A" INSTEAD OF LEAVING BLANK LINES. ALL QUESTIONS CAN BE DIRECTED TO MEMBERSHIP SERVICES AT FLORIDA HOSPICES AND PALLIATIVE CARE (FHPC), AT (850) 922-7717. IF THE PRE-FILLED INFORMATION IS INCORRECT, PLEASE MARK THROUGH IT AND MAKE CORRECTIONS TO THE SIDE. **We recognize the highly confidential nature of some of this information. It will only be used by FHPC in case of an emergency.**

#### APPLICATION (PAGE ONE)

Business Name:	
Mailing Address:	Category: <b>Patron Associate Member</b>
Telephone: Toll Free:	Website:
Fax:	Business Email:

#### PRIMARY CONTACT INFORMATION:

Prefix: <input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Rev. <input type="checkbox"/>	First:	Last:
Suffix: <input type="checkbox"/> MD <input type="checkbox"/> RN <input type="checkbox"/> BSN <input type="checkbox"/> MSW <input type="checkbox"/> Ph.D. <input type="checkbox"/> Other:		
Business Name:	Title:	
Mailing Address:		
Phone:		
Home Phone:	Email:	
Cell Phone:		

APPLICATION (PAGE TWO)

SECONDARY CONTACT INFORMATION:

Prefix: <input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/>	First:	Last:
Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Rev. <input type="checkbox"/>		
Suffix: <input type="checkbox"/> MD <input type="checkbox"/> RN <input type="checkbox"/> BSN <input type="checkbox"/> MSW <input type="checkbox"/> Ph.D. <input type="checkbox"/>	Other:	
Business Name:	Title:	
Mailing Address:		
Phone:		
Home Phone:	Email:	
Cell Phone:		

ADDITIONAL CONTACT INFORMATION :

Prefix: <input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/>	First:	Last:
Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Rev. <input type="checkbox"/>		
Suffix: <input type="checkbox"/> MD <input type="checkbox"/> RN <input type="checkbox"/> BSN <input type="checkbox"/> MSW <input type="checkbox"/> Ph.D. <input type="checkbox"/>	Other:	
Business Name:	Title:	
Mailing Address:		
Phone:		
Home Phone:	Email:	
Cell Phone:		

BUSINESS CLASSIFICATION:

(On the line below, write where you would list your business in the Yellow pages or by the Standard Industry Code)

BUSINESS DESCRIPTION:

Please provide on the CD with your logo or include below a short (200 word or less) description of your business for use in the FHPC Membership Directory. Enclose any descriptive brochures or other information that you would like FHPC to have in its files.

Please type or print clearly.

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APPLICATION (PAGE THREE)

**PLEASE READ AND SIGN:**

*FHPC is an IRS 501(c)(3) charitable organization and contributions may be tax deductible as charitable donations (less 5% for lobbying activities) or allowable business expense. Please consult your tax advisor.*

I understand that by providing my mailing address, e-mail, telephone number, and fax number, I consent to receive communications via regular mail, e-mail, telephone, and/or fax sent by or on behalf of FHPC.

**SIGNATURE OF PRIMARY CONTACT:** \_\_\_\_\_

**DATE MEMBERSHIP ESTABLISHED:** \_\_\_\_\_

**PATRON ASSOCIATE MEMBERSHIP** **\$2,500.00**

**TOTAL INVESTMENT** **\$ \_\_\_\_\_ .00**

**PAYMENT INFORMATION:**

Make **checks** payable to Florida Hospices and Palliative Care, Inc.

**Visa**       **MasterCard**       **American Express (check one)**

Name on Credit Card: \_\_\_\_\_

Credit Card #: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Billing Address: \_\_\_\_\_

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