

2010 Membership Application Form



Annual Dues (January 1 - December 31)

_____ Organization dues - \$250

_____ Community Coalition dues - \$100

_____ Individual dues - \$50

_____ Tax Deductible Donation **Total Amount Enclosed \$** _____

Please complete:

Name _____

Title _____

Organization _____

Address _____

City _____ Zip Code _____

Email _____

Phone _____ Fax _____

Website _____

Optional for organizational or community coalition membership:

Name of representative #2 _____

Title _____

Organization _____

Address _____

City _____ Zip Code _____

Email _____

Phone _____ Fax _____

Payment Information: Check enclosed (payable to CCCC) Credit card (Visa or Master Card):

CC#: _____ exp. ___/___ Security Code: _____

Billing Address: _____

Signature: _____

Please send payment or payment information and return with form to: Coalition for Compassionate Care of California, 1215 K Street, Suite 1917, Sacramento, CA 95814

Membership Agreement:

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

Signature of Applicant

Print Name

Date

Questions? - Please call us at (916) 489-2222 or email us at info@CoalitionCCC.org