ST. JOHNS RIVER RURAL HEALTH NETWORK

Support Connect Improve

Membership Application

I. Organization Information

Company /Organization Name: _____

Address Line 1:_____

Address Line 2:_____

City:_____

State: _____ Zip:_____

Telephone: _____ Fax: _____

General E-Mail Address: _____

Website Address: _____

This office: ☐Branch Office ☐Office HQ ☐Other:_____

II. Primary Contact

Please supply information about the person who will be the primary point of contact with your organization.
[This is the person who will receive information from our office.]

Please Select Association: ☐**Associate/General Member** ☐**New Member** ☐**Board Officer** ☐**Board Member** ☐ **Volunteer/ Intern**

Salutation: __ First Name: _____ Last Name: _____
(Mr., Mrs. Miss., Dr,)

Title: _____

Email: _____

Phone: _____ Cell:_____ Fax:_____

Enter the following information only if different from above

Address 1:_____

Address 2:_____

City: _____ State: _____ Zip Code: _____

III. Committees *(I wish to join/receive information about the following committees):*

☐Chronic Disease Management ☐Health IT ☐Healthcare Professional/Provider Recruitment ☐ Outreach/Marketing

☐Grants ☐Accreditations ☐Conferences/Seminars/Trainings ☐ Community Health

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IV. Additional Information *(We* would appreciate if you would take a moment to answer the following questions if applicable):

How many employees does your company have? _____

What is the main business/service that your company engages in? _____

My company is interested in:

Participating in ☐Hosting a Community Health /Seminar Event ☐ Accepting interns/shadows ☐Other_____

Please contact me about these opportunities via

☐Email ☐ Phone ☐Direct Mail

V. Additional Contacts *(*The following contacts/organization would also like to be put on the general mailing list and/ or a selected committee):

Company /Organization/_____

Address Line 1:_____

Address Line 2:_____

City:_____

State: _____ Zip:_____

Telephone: _____ Fax: _____

General E-Mail Address: _____

Website Address: _____

****

Salutation: __ First Name: _____ Last Name: _____
(Mr., Mrs. Miss., Dr,)

Title: _____

Email: _____

Phone: _____ Cell:_____ Fax:_____

Please List Committee:_____

Mail/ Fax Application
Health Planning Council
St.Johns River Rural Health Network
100 N. Laura Street
Jacksonville, FL 32202

FAX: 904.301.3682