



Name: \_\_\_\_\_

Organization: \_\_\_\_\_

Position: \_\_\_\_\_

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

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

.....  
*Dues Schedule*

**Organizational** (0.1% of annual operating budget) **Minimum: \$500**  
 Please specify: state or local health planning or CON program with public decision-making process, federal program with planning responsibility, other (describe):

**Affiliate** (circle one) **Regular: \$250** **Supporting: \$500**  
 Please specify: provider, payer/insurer, business, labor, consumer, educational institution, government, or other subscribing to planning principles (describe):

**Individual** (circle one) **Regular: \$75** **Supporting: \$250** **Sustaining: \$500+**  
 Please specify: health planner, provider, payer/insurer, business, labor, consumer, educator, govt. official, other supporter of principals of health planning  
 (describe):

**Student**  
 (must be enrolled in full-time studies and provide a letter from institution) **\$25**  
 Please specify: name of institution and program, undergraduate or graduate related to community health planning or other planning discipline (describe):

Amount Enclosed: