Indiana Primary Health Care Association

Affiliate, Individual, and Health Care Provider in Training

2010/11 Membership Application

Please send completed application, payment, and all requested materials to:

● IPHCA●
Attention: Member Services Specialist
429 N. Pennsylvania St., Suite 333
Indianapolis, IN 46204

We sincerely appreciate your care in completing all forms included in this application.

For questions, please call Stephanie Suddeth at 317-630-0845
www.indianapca.org

Indiana Primary Health Care Association's (IPHCA) mission is to advocate for quality health care for everyone in Indiana, and to support the development of community-oriented initiatives that are:

●Affordable ●Available ●Accessible ●Appropriate ●Acceptable

2010/11 IPHCA Membership Application

☐ New Application ☐ Renewal Application

Welcome, and thank you for your interest in the Indiana Primary Health Care Association.

Applicant Name:	2010/11 Membership Year
Organization: ____ Mailing Address: ____ ____ City: State: Zip: ____ Telephone: ____ FAX: ____ Email: ____ Website: ____ • A membership is not active until approval of the application by the IPHCA Board of Directors. IPHCA reserves the right to reclassify a member to a different category when appropriate. The member will receive a letter of acceptance from IPHCA in 6-8 weeks. • *Please note: As a condition of membership, the above contact information will be published in our membership directory and on the IPHCA website. Employee contact information may also be published in the membership directory, and/or on the IPHCA website.*	April 1, 2010- March 31, 2011 Membership Type ____ Affiliate $500.00 ____ Individual $100.00 OR Individual at: ____ Silver Level $125.00 ____ Gold Level $150.00 ____ Health Care Provider in Training $50.00 *Please see page 6 for membership descriptions*

PAYMENT INFORMATION

Please include payment with application and required documents.

_____My check is enclosed and made payable to “IPHCA” in the amount of: $________________

_____Please charge my (circle one): VISA MASTERCARD

Card number: ____

Expiration Date: ______________________________________

Name as it appears on card (please print):____

Address card is registered to: ____

____

Cardholder’s Signature: ____

- By signing below, you indicate your support for the work of the Indiana Primary Health Care Association and a desire to become a supporting member
- IPHCA’s membership list may not be sold or shared with any non-member entity or non-member individual
- Information gathered through any participation or interactions as an IPHCA member must be treated as confidential and considered proprietary in nature

Signed:____Title:______________________

Dated: _________________________

Please send all forms and payment to:

Indiana Primary Health Care Association
429 N. Pennsylvania St., Suite 333
Indianapolis, Indiana 46204

For questions call the Member Services Specialist at 317-630-0845

MEMBER INVOLVEMENT

Member involvement is vital to the success of IPHCA. Please complete the following sections.

Designation to the IPHCA General Assembly Meeting	
Name:	Title:
Address (if different from main address listed on pg. 2):	Telephone: Fax:
City: State: Zip:	E-mail:

Individual, Affiliate and Health Care Provider members *may be invited to serve on an IPHCA committee*. If you have any interest in serving on any of the committees, please check your area of interest.

Standing Committees of the Board

- Membership Committee
- Finance Committee
- Personnel Committee
- Health Policy Committee

IPHCA
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