

Please complete the membership information below and return this form with your payment to the IRHA office. Membership runs from July 1, 2008 to June 30, 2009.

Name: _____ **Title:** _____
(Name of Primary Contact if Organizational Member)

Organization: _____
Address: _____
City, State Zip: _____ **County:** _____
Telephone: _____ **Fax:** _____
E-mail: _____

Please indicate your affiliation:

- EMS Healthcare Advocacy
- Hospital State Agency
- Medical Center/Clinic Private Provider
- Provider Association Public Health Department
- Health Professional Education
- Other _____

Please check the appropriate membership renewal category:

	One-Year Membership Expires June 30, 2009	Two-Year Membership Expires June 30, 2010
Student	<input type="checkbox"/> \$15	<input type="checkbox"/> \$27
Individual	<input type="checkbox"/> \$50	<input type="checkbox"/> \$90
Organizational (up to 4 members)	<input type="checkbox"/> \$200	<input type="checkbox"/> \$360

Pay by check or credit card. Mail payments to:

Illinois Rural Health Association
310 E. Adams St., Springfield, IL 62701

Membership dues to the IRHA are not tax deductible as a charitable contribution for income tax purposes. However, they may be deductible as ordinary and necessary business expenses.

IRHA takes Visa or Mastercard; Exp. Date: _____
 Card #: _____
 Signature: _____

Fax: 217-522-2729

Your E-Mail Address is Important!

By providing a fax number and email address, you are agreeing to receive fax and emails from the association that may contain a message of commercial nature. IRHA does NOT sell email or fax information.

Please be sure to review your email address for accuracy and update it if necessary. The IRHA newsletters, as well as other association materials, are being distributed electronically, and we want to be sure that you are receiving all the information.

Name: _____
Title: _____
Address: _____
City, State Zip: _____
Phone: _____
Fax: _____
E-mail: _____

Name: _____
Title: _____
Address: _____
City, State Zip: _____
Phone: _____
Fax: _____
E-mail: _____

Name: _____
Title: _____
Address: _____
City, State Zip: _____
Phone: _____
Fax: _____
E-mail: _____