

Illinois Rural Health Association

2010-2011 Membership Renewal Form

Please complete the membership information below and return this form with your payment to the IRHA office by June 30, 2010.

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 _____

Interested in serving on a committee?

- Legislative Membership EMS Mental Health
 Financial sustainability Education/Research Oral Health

Please check the appropriate membership renewal category:

- | | | |
|-------------------------------------|--|-------|
| | One-Year Membership
Expires June 30, 2011 | |
| Student | <input type="checkbox"/> | \$15 |
| Individual | <input type="checkbox"/> | \$50 |
| Organizational
(up to 4 members) | <input type="checkbox"/> | \$200 |

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: _____

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: _____ CVV2: _____ (3 digit code on back of card)

Card #: _____

Billing Address: _____

City: _____ : Zip Code _____

Signature: _____

Fax: 217-522-2729

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

Thank you for your support. For more information please call (866) 921-4742.