

# 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<br>Expires June 30, 2011 |       |
| Student                             | <input type="checkbox"/>                     | \$15  |
| Individual                          | <input type="checkbox"/>                     | \$50  |
| Organizational<br>(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.**