

Affiliate Membership Application



Florida Hospice & Palliative Care Association (FHPCA) invites you to join the Affiliate Membership program. Your dollars contribute to our community based and directed hospice programs that provide so many extra services to their communities. Please complete and return this application and we will begin processing your membership. This application can be mailed or emailed to our office based on your preferred method of payment.

Any questions about Affiliate Membership and Benefits can be directed to Membership Services at FHPCA by calling (877) 783-1922 or emailing info@floridahospices.org. Please don't hesitate to reach out to provide updates about your company.

We recognize the highly confidential nature of some of this information. It will only be used by FHPCA in case of an emergency.

BUSINESS INFORMATION:

Business Name:		
Mailing Address:	Membership Level: <input type="checkbox"/> Corporate-Patron <input type="checkbox"/> Patron <input type="checkbox"/> Associate	
Office Phone: Toll Free Phone: Fax:	Website: Business email:	
Social Media:	<input type="checkbox"/> Facebook <input type="checkbox"/> Twitter <input type="checkbox"/> LinkedIn	<input type="checkbox"/> Google+ <input type="checkbox"/> Blog: <input type="checkbox"/> Other:
I was referred by:		

PRIMARY CONTACT:

This person will receive all communication from FHPCA events, news, renewals, etc.

First:		Last:
Prefix:	Suffix:	Job Title:
Business Name (if different):		
Mailing Address (if different):		
Work Phone: Cell Phone:	Email:	

EVENT CONTACT:

If the Primary Contact is not the person we should contact regarding an event, please provide that information below.

First:		Last:
Prefix:	Suffix:	Job Title:
Business Name (if different):		
Mailing Address (if different):		
Work Phone: Cell Phone:	Email:	

MARKETING CONTACT:

The person FHPCA should contact regarding promotion of your company through our various communications (i.e. blog, e-newsletter, website, etc.)

First:		Last:
Prefix:	Suffix:	Job Title:
Business Name (if different):		
Mailing Address (if different):		
Work Phone:	Email:	
Cell Phone:		

BUSINESS CLASSIFICATION (please check only one box):

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Accreditation | <input type="checkbox"/> Foundation | <input type="checkbox"/> Medical Supply | <input type="checkbox"/> Research & Education |
| <input type="checkbox"/> Consultant | <input type="checkbox"/> Insurance/Risk Management | <input type="checkbox"/> Pharmaceutical | <input type="checkbox"/> Software Vendor |
| <input type="checkbox"/> Durable Medical Equipment | <input type="checkbox"/> Legal Services | <input type="checkbox"/> Publisher | <input type="checkbox"/> Staffing Agency/Service |
| <input type="checkbox"/> Other: | | | |

Please Read and Sign

FHPCA is an IRS 501 (c)(3) charitable organization and contributions may be tax deductible as charitable donations (less 5% for lobbying activities) or allowable business expense. Please consult your tax advisor.

SIGNATURE OF PRIMARY CONTACT: _____

I understand that by providing my mailing address, email, telephone number, and fax number, I consent to receive communications via regular mail, email, telephone, and/or fax sent by or on behalf of FHPCA.

I further understand that events scheduled by the FHPCA Board of Directors are by invitation only and in order to attend any such event I must register by the deadline and provide all requested information. As an invited guest, I will honor the agenda as set by the board and will not schedule conflicting activities that might take away from the agenda.

- | | |
|--|-------------|
| <input type="checkbox"/> Corporate-Patron Membership | \$12,500.00 |
| <input type="checkbox"/> Patron Membership | \$3,000.00 |
| <input type="checkbox"/> Associate Membership | \$500.00 |

Total Investment: _____

PAYMENT INFORMATION

☐ VISA ☐ Mastercard ☐ Discover ☐ American Express

Name on Credit Card: _____

Credit Card #: _____

Expiration Date: _____ Code: _____

Billing Address: _____

Make checks payable to
Florida Hospice & Palliative Care Association, Inc.

In order for your application to be processed, please ensure all of the following are included in your submission:

1. Payment
2. Application:

- | | |
|--------------------------|--|
| <input type="checkbox"/> | Completed and signed application |
| <input type="checkbox"/> | Company logo (.pdf or high quality .jpeg format) |
| <input type="checkbox"/> | Short (200 words or less) description of your business for use in the membership directory |

Please send all materials and invoice requests to Member Services at info@floridahospices.org