



2007 PAIN ORGANIZATION MEMBERSHIP APPLICATION

The Pain Membership year runs from January 1st through December 31st.

Name of Organization: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____ Website: _____

As a member of the Indiana Pain Initiative, I consent to the use of the provided email addresses/fax numbers for receipt of organization notices and newsletters. Please initial _____

Organization Director/CEO: _____ Email: _____

Primary Contact Name: _____ Title: _____ Email: _____

(Primary Contact person will receive all mailings, etc. from Indiana Pain Initiative and will serve as Voting Delegate)

Organization Type (please check only one):

- | | |
|---|---|
| <input type="checkbox"/> Community Advocacy Group | <input type="checkbox"/> Long-Term Care Facility |
| <input type="checkbox"/> Educational Institution | <input type="checkbox"/> Pain Clinic |
| <input type="checkbox"/> Home Care Agency | <input type="checkbox"/> Pharmacy |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Private Medical Practice |
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Other (please list): _____ |

Please describe the services your organization provides: _____

Please list the counties your organization serves: _____

Is your organization certified? Yes No

If yes, please list certifying agency and type of certification: _____

Line 1 **Total Membership Dues for 2007** \$500.00

Line 2 **Contribution to IN-PI** _____

Line 3 **Total Enclosed** _____

Please return this form and payment in full postmarked to:

Please make checks payable to IHPCO and mail to: INDIANA HOSPICE & PALLIATIVE CARE ORGANIZATION,
10 West Market Street, Suite 1720, Indianapolis, IN 46204

Fax 317-464-5146 or E-mail: krussell-sullivan@ihpco.org

Payable by check or credit card! *Credit Card Payment* (all fields are required to process

charges) Payment Method: Check Charge Card

Name/Organization as shown on Credit Card:

Card Type: Visa MasterCard Card # _____ Exp. Date: _____

Billing Address: _____

Signature: _____

FOR OFFICE USE ONLY:

Check Number: _____ Amount: \$ _____ Date Received: _____ Postmark Date: _____