



## **2007 PAIN PROFESSIONAL MEMBERSHIP APPLICATION**

The Pain Membership year runs from January 1<sup>st</sup> through December 31<sup>st</sup>.

Name: \_\_\_\_\_

I would like to receive organizational notices at my:  Home  Office

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Home Fax: \_\_\_\_\_

Home Email: \_\_\_\_\_

Title: \_\_\_\_\_

Organization Affiliated With: \_\_\_\_\_

Business Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Business Fax: \_\_\_\_\_

Business Email: \_\_\_\_\_

As a member of the Indiana Pain Initiative, I consent to the use of my email address for receipt of organization notices and newsletters.

INITIALS \_\_\_\_\_

Individual Supporter Membership Dues \$ 50.00

### **Contribution to support the work of Indiana Pain Initiative**

Your donation will help the Indiana Pain Initiative educate Hoosiers on pain and symptom management.

\$ \_\_\_\_\_

TOTAL ENCLOSED \$ \_\_\_\_\_

**Questions?** Feel free to contact our office at **317-464-5145** or [krussell-sullivan@ihpco.org](mailto:krussell-sullivan@ihpco.org)

### **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](mailto:krussell-sullivan@ihpco.org)

Payment Method:  Check  Charge Card

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

Name/Organization as shown on Credit Card:

Card Type:  Visa  MasterCard Card # \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Billing Address for Credit Card: \_\_\_\_\_

Date Postmarked _____	Date Received _____	Check # _____	Amount Received _____
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***Indiana Pain Initiative***

10 W. Market St., Ste. 1720 ♦ Indianapolis, IN 46204