Indiana Hospice & Palliative Care Organization, Inc.

2009 HOSPICE & PALLIATIVE CARE PROFESSIONAL APPLICATION

A Hospice & Palliative Care Professional Membership is for members of a hospice or palliative care team only!

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 IHPCO I consent to the use of my email address/fax number for receipt of organization notices and newsletters. ____________Initials

Hospice & Palliative Care Professional Membership Dues $ 45.00
Discounted Pain Initiative Professional Membership Dues $ 30.00

Contribution to support the work of IHPCO, a 501(c)(3) organization
90% of Americans state that they would prefer to die at home, although only 10% of Hoosiers receive this wish. Your donation will help IHPCO educate Hoosiers on end-of-life choices. $ __________

Donation to: ❒ Pain Initiative ❒ IHPCO ❒ Split

TOTAL ENCLOSED $ __________

If paying with a credit card, please fill out the following:

Which credit card will be charged? ❒ VISA ❒ MasterCard

Card Number: ______________________ Expiration Date: ____________

Name Printed on Card: ____

Complete Mailing Address for Credit Card: ______________________________

I authorize the Indiana Hospice & Palliative Care Organization to charge the above credit card for the amount listed above.

Please sign ____

Please complete this form and return with your check to:

Indiana Hospice & Palliative Care Organization, 3921 N. Meridian St., Suite 225, Indianapolis, IN 46208
Phone: (317) 464-5145, Fax: (317) 464-5146, www.ihpco.org

FOR OFFICE USE ONLY:

Check Number:__________ **Amount: $**__________ **Date Received:**__________ **Postmarked Date:** __________