New York State Association for Rural Health
2009 Membership Application

Please remit payment along with completed form

Membership Dues

Please check one type only

____ Student	$10
____ Individual	$55
Organizational (based on revenue)	
____ less than $99,999	$125
____ $100,000 - $250,000	$140
____ $250,001 - $499,999	$150
____ $500,000 - $999,999	$160
____ $1 Million - $2.9 Million	$175
____ $3 Million and above	$200

Payment Information

Please make checks payable to: NYSARH

remit to: NYSARH
10950 County Rd. 92
Wayland, NY 14572

OR

credit card _____ MasterCard _____ VISA

Card # _____

Exp. Date _____

Cardholder _____

Signature _____

Member or Primary Contact Information

Organization

Member Name/Title

Email

Mailing Address

City

State Zip Code

County

Phone

Fax

Secondary Contact Information (Organizational only)

Name

Title

Email

Organizational Information

Type of Organization (check the one that best describes your organization or business):

___ Health Care/Type: _____

___Human Serv/Type: _____

___Gov't Agency/Type: _____

___ Agriculture ___ Education

___ Environmental ___ Faith-based

Other _____

_____

NYSARH Committees

Please select NYSARH committees in which you are interested in participating:

____ By-Laws
____ Conference Planning
____ Legislative/Health Advocacy
____ Membership
____ Nominating
____ Organizational Development
____ Public Relations
____ Quality Through Collaboration

If your interest in becoming a NYSARH member is the result of someone encouraging you to do so, who may we thank for this? Name of person who recruited you: