



Membership Application

Name of Organization _____

Contact _____

Title _____

Number of Sites/Providers _____

Address _____

City/State/Zip _____

Phone _____

Email _____

*** Please provide a list of all sites and their addresses on a separate sheet of paper***

Please check all that apply:

- | | |
|-----------------------------------|---------------------------------|
| <input type="checkbox"/> Grantee | <input type="checkbox"/> Dental |
| <input type="checkbox"/> CHC | <input type="checkbox"/> Urban |
| <input type="checkbox"/> Migrant | <input type="checkbox"/> Rural |
| <input type="checkbox"/> Homeless | <input type="checkbox"/> NHSC |

Membership Fees

Please check which type of membership:

- Organizational\$400
- Supporting\$400
- Individual\$100

Amount Enclosed _____

Please return your application with a check made payable to

MWCN
321 West Lake Lansing Road
East Lansing, MI 48823
Attn:Amanda Campbell

Committees

Members are encouraged to join committees if they are interested in becoming more involved in the network:

- Education Committee** - training needs, conferences, conference calls
- Finance Committee** - budget and quarterly reports
- Membership Committee** - membership recruitment and needs
- Newsletter Committee** - gather articles and information for the MWCN newsletter
- Quality Committee** - Patient Satisfaction Survey, Risk Management Software
- Research Committee** - high quality research activities

Name _____

Email _____

Committee _____

Name _____

Email _____

Committee _____