

NATIONAL POLST COLLABORATIVE

STATE MEMBERSHIP APPLICATION



State Organization Name

Website

PRIMARY CONTACT

Name Title

Address

Phone E-mail

SECONDARY CONTACT

Name Title

Address

Phone E-mail

WHICH OF THE FOLLOWING CATEGORIES BEST DESCRIBES YOUR STATE ORGANIZATIONAL MODEL?

Independent Organization (please specify name)

Program, as part of another organization (please specify sponsor name)

Governmental (please specify department name)

Other (please describe)

Non-Profit For-Profit

ATTACHMENTS

- High Resolution Logo
- Website URL
- Brief Organization Bio

By signing below, I am indicating that I am authorized to commit my organization to joining the Membership of NPC. I understand that my organization will be invoiced based on the established fee schedule. My organization may choose to terminate its membership at any time, but will not be entitled to a refund of dues paid.

Signature

Name

Title

THANK YOU FOR JOINING THE NATIONAL POLST COLLABORATIVE

ANNUAL MEMBERSHIP DUES

\$1000



NATIONAL POLST COLLABORATIVE

A Program of the Louisiana Health Care Quality Forum

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