CHAPCA Professional Membership Form (2020)

CHAPCA

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

E-Mail: _____

Professional Member Education Pass:

- Significant discounts on CHAPCA education.

Membership Agreement:

As an applicant to the California Hospice & Palliative Care Association, I do affirm to voluntarily abide by and support the goals and objectives of the organization. In addition, I agree to accept fax and e-mail communications from CHAPCA relative to the business of the Association and the Foundation.

_____ _____ _____

Signature of Applicant | Printed Name | Date

PROFESSIONAL EDUCATION PASS DUES $225

Method of Payment:

❒ AMEX ❒ MasterCard ❒ Visa

Card No: _____ Exp. Date: _____ Card ID #: _____

_____ _____

Signature (required if using credit card) | Name on credit card (please print)

_____ _____

Card Billing Address | City, ST, Zip

Send Application with Payment To:
P.O. Box 340698 Sacramento, CA 95834
info@calhopsice.org or 916-925-3780