Membership Application

Organization's Name:

Address:

Phone:

Email:

Website:

Name of Individual(s) and title of organization representative:

Type of Business:

Not for Profit? (Attach documentation)

Mission Statement/Vision of Business:

Service Area of Organization:

Reason for Interest in joining the MOV Rural Health Alliance Membership:

Membership level desired:

Voting Member (please find definition and cost attached) _____

Non Voting Member ____

Associate ____