



Communication  
consensus  
and advocacy

## Membership Form

If your organization would like to become a member of the Health Professions Network (HPN) please fill in the following information.

### Part One – Tell us about your Organization

Organization:

Address:

City:  State:  Zip:

Phone:  Fax:

Web site:  E-mail:

Membership into the HPN is reviewed by the Board of Directors during their regularly scheduled meetings. In order to help us understand how your organization will be represented within HPN, we need the following information:

1. Please provide a brief description (in your own words) of your organization or company. (You can also attach your mission, vision, values statement if you wish.)

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2. Is your organization or company a non-profit or for-profit entity?

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3. How do you think becoming a member of HPN will help your organization or company?

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**Part Two – Tell us about your organization’s leadership**

You should select two people in your organization who are upper management decision makers. These two individuals will represent your organization or company at our Spring and Fall meetings and will remain your representatives until further notice from your organization or company.

**Representative 1**

Name:

Title:

Address:

City:  State:  Zip:

Phone:  Fax:

Comments:  E-mail:

**Representative 2**

Name:

Title:

Address:

City:  State:  Zip:

Phone:  Fax:

Comments:  E-mail:

[ ] Yes, we have reviewed and agree to abide by the HPN Bylaws which can be found on the HPN Website or directly at the following link: ([www.healthpronet.org/about/bylaws.html](http://www.healthpronet.org/about/bylaws.html))