



P O Box 2193 Brandon, MS 39043
Phone/ Fax: 800-521-9414

Healthcare Provider Membership Application

Date: _____

Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Contact: _____ Title: _____

Secondary Contact: _____ Title: _____

Phone: _____ Fax: _____

Email: _____ Website: _____

Services Provided: _____

Additional members under this application:

Name: _____ Title: _____

Address: _____ City: _____ ST: _____ Zip: _____

Phone: _____ Email: _____

Name: _____ Title: _____

Address: _____ City: _____ ST: _____ Zip: _____

Phone: _____ Email: _____

Name: _____ Title: _____

Address: _____ City: _____ ST: _____ Zip: _____

Phone: _____ Email: _____

Name: _____ Title: _____

Address: _____ City: _____ ST: _____ Zip: _____

Phone: _____ Email: _____

Name: _____ Title: _____

Address: _____ City: _____ ST: _____ Zip: _____

Phone: _____ Email: _____

**Please attach additional pages if needed.

Areas serviced:

City _____ County _____

Healthcare Provider Membership Fee: \$ 250.00

*Includes 2 Contacts

Additional members: _____ x \$ 28.00* = \$ _____.

*Discounted under Corporate Membership

Total Due: \$

All members will receive membership cards. These cards can be used at events, seminars and with Clyde's Hope vendors where discounts are offered.

A tax deductible receipt will be mailed when payment is received.

Please call for credit card authorization forms if needed.

Please mail application and payment to:

Clyde's Hope, Inc.
P O Box 2193
Brandon, MS 39043

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