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| **MEMBERSHIP APPLICATION** |
| **ORGANIZATIONAL MEMBER INFORMATION**(Please complete a separate form for each clinic.) |
| Membership category *(Please indicate)* | * CARHC clinic membership
 | * Affiliate

non-clinic membership |
| Clinic Name: |
| Name of Health System or District Affiliation (if applicable): |
| Name of Hospital or Organization (if applicable): |
| **Clinic or Organization** | Physical Street Address: |
| City: | State: | ZIP Code: | County: |
| Phone: | Fax: | Email: | Website: |
| Mailing Address (if different): |
| City: | State: | ZIP Code: | Clinic CMS Number: |
| RHC category (Please check) | * Independent
 | * Provider-Based
 | * Affiliate
 |
| Ownership category (Please check) | * Nonprofit
 | * For Profit-Corporation
 | * Government-Federal
 |
|  | * For Profit-Partnership
 | * Government-Local
 |
|  | * For Profit-Individual
 |  |
| Clinics Only: | Annual RHC Encounters: | RHC Certification Year: | # RHC Employees (Not FTE): |
| Affiliates: Please provide information about your interest in RHCs. (This may be used in your directory listing.) |
| Member Contacts: Name(s), Emails, and Direct Phone Number. (We encourage multiple contacts in your organization.) (Please indicate the primary contact and billing contact.) |
| **ANNUAL DUES** |
| $300 | CARHC Member Clinic |
| $100 | Additional clinic Membership (Please complete a separate Membership Application for each additional member, additional clinics must be within the same health system) |
| $350 | Affiliates (Non-Clinic Member) |
| Please mail your application and payment to **CARHC, 5817 N. Maruyama, Fresno, CA 93723.**If you have any questions, call us at **559-706-8226** or email to **Info@CARHC.org.** |
| **SIGNATURE** |
| Signature of applicant: | Date: |

[www.CARHC.org](http://www.carhc.org/) Version 13, 01/11/22