The NW LGBT Senior Care Providers Network

Membership Application

Please print clearly

Company Name _____

Company Description (2-3 sentences) _____

_____

_____

_____

Name of Contact and Title _____

Email Address _____

Phone (_____) _____

Mailing Address _____

Website _____

If desired – please send your company logo to tiffanykopec@icloud.com

- ☐ **I have signed and attached the Non-Disclosure form**
- ☐ **I have submitted the $100 Membership Fee**
- ☐ **I understand that future membership will be based upon my attendance at a minimum of 4 meetings in the 12 months encompassing my initial application.**

By signing below, I confirm that I have the authority to enter into this membership on behalf of named company and understand that membership is based on NWLGBT SCPN Board approval and can be revoked at any time.

Signature _____ **Date** _____