



## MEMBERSHIP APPLICATION For Corporations

www.nationalperinatal.org

Phone: 888-971-3295 Fax: 717-920-1390

### PLEASE PROVIDE COMPANY/ ORGANIZATION INFORMATION

Name	:	_____
Address	:	_____
City	:	_____
State	:	_____
Zip	:	_____
Website:		

### PLEASE PROVIDE COMPLETE PRIMARY CONTACT INFORMATION

First Name:	_____	Title	:	_____	
Last Name:	_____	Work Phone	:	_____	
Address	:	_____	Fax	:	_____
City	:	_____	E-mail	:	_____
State	:	_____			
Zip	:	_____			

### NPA Status (Please check the appropriate box)

- New Member       Renewing Member

### Membership Category (Please check the membership category that applies to you)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Corporation Silver \$750        | <input type="checkbox"/> Level I Hospital \$350           | <input type="checkbox"/> Non-Profit Organization \$200  |
| <input type="checkbox"/> Corporation Gold \$5000         | <input type="checkbox"/> Level II Hospital \$750          | <input type="checkbox"/> Health Department \$300        |
| <input type="checkbox"/> Corporation Platinum \$10,000   | <input type="checkbox"/> Level III Hospital \$1250        | <input type="checkbox"/> Educational Institution \$5000 |
| <input type="checkbox"/> Corporation Supporting \$15,000 | <input type="checkbox"/> Regional Perinatal Center \$1250 | <input type="checkbox"/> International \$90             |



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### Journal Subscription (Please check if you wish to subscribe)

- Yes, I wish to subscribe/renew my subscription to the Journal of Perinatology at the reduced rate of \$55 (per year) with my membership.

### Company/Organization Description (Please check the category that applies)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Hospital                 | <input type="checkbox"/> Educational Institution | <input type="checkbox"/> Pharmaceuticals              |
| <input type="checkbox"/> Medical Equipment        | <input type="checkbox"/> Health Dept. (State)    | <input type="checkbox"/> Health Dept. (County)        |
| <input type="checkbox"/> Health Dept. (Municipal) | <input type="checkbox"/> Community Health Center | <input type="checkbox"/> Community Based Organization |
| <input type="checkbox"/> Manufacturing            | <input type="checkbox"/> Retail                  | <input type="checkbox"/> Food Service                 |
| <input type="checkbox"/> Transportation           | <input type="checkbox"/> Food Service            | <input type="checkbox"/> Other _____                  |

### Payment Method (If paying by Credit Card)

- Visa  
 MasterCard

### Credit Card Information

Card Number	:	_____
Expiration Number:		_____
Name on card	:	_____
Total Charged	:	\$ _____
Signature	:	_____

### Payment Method (If paying by check)

- Check Check Amount: \$ \_\_\_\_\_

Send Membership Application with payment to:

**National Perinatal Association  
2090 Linglestown Rd., Suite 107  
Harrisburg, PA 17110**