



www.nationalperinatal.org

Phone: 888-971-3295 Fax: 607-772-0468

MEMBERSHIP APPLICATION

For Corporations

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
457 State Street
Binghamton, NY 13901**