



www.nationalperinatal.org

Phone: 888-971-3295 Fax: 703-684-5968

## 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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## MEMBERSHIP APPLICATION

For Corporations

### 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  
2000 North Beauregard St., 6<sup>th</sup> Floor  
Alexandria, VA 22311**