



**MEMBERSHIP  
APPLICATION**  
For Support Groups

www.nationalperinatal.org

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

**PLEASE PROVIDE COMPANY/ORGANIZATION INFORMATION**

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

**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

**Organizational Status** (Please check the category that applies to you)

- Incorporated       Non-Profit       Informal Group       Hospital Based



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## MEMBERSHIP APPLICATION

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### Type of Program/Group (Please check one)

- |  |   |                                      |
|--|---|--------------------------------------|
| <input type="checkbox"/> Preemie Support   | <input type="checkbox"/> Published Document / Magazine/newsletter | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Parent to Parent  | <input type="checkbox"/> Published Document / other _____         |                                      |
| <input type="checkbox"/> Grief/bereavement | <input type="checkbox"/> Special Needs Children                   |                                      |

### Organizational Structure (Please provide details)

Board of Directors?	<input type="checkbox"/> Yes <input type="checkbox"/> No	# of members _____
Hired Staff?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Volunteer Staff Special Training?	<input type="checkbox"/> Yes <input type="checkbox"/> No	# of volunteers _____
Frequency of program?	_____	
Fee Structure?	<input type="checkbox"/> Free <input type="checkbox"/> Scholarships <input type="checkbox"/> Other	<input type="checkbox"/> Fee Fee amount \$

### Membership Category

- Family Support Group \$45

### 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.

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

- Visa  
 MasterCard



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**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**

**Comment Section** (Please provide comments)

Recent Projects/Successes \_\_\_\_\_

Recent Challenges/Problems \_\_\_\_\_

Other Comments \_\_\_\_\_

Suggestions For NPA \_\_\_\_\_