Palliative Care Membership Application

Welcome to the only association in Virginia that focuses exclusively on Hospice and Palliative Care and the concerns of providers. We are the one association committed to improving end-of-life care and expanding access to all in need across the Commonwealth of Virginia. **Enjoy Member benefits while strengthening the VOICE for hospices and palliative care in Virginia.**

Palliative Care Members are defined as: Licensed Hospice or Palliative Care organizations that support the VAHPC mission and purpose.

- Help us keep an accurate membership database by answering the questions on this page.
- Sign and date this application and return via mail to VAHPC, P.O. Box 70025, Richmond, VA 23255 or submit via email as an attachment to mwlindsey@virginiahospices.org.
- Please remit your completed application with payment by check by **March 1, 2021**.
- Make checks payable to VAHPC.

(PLEASE PRINT)

Member/Organization Name: _____

CEO/Administrator: _____

Local On-Site Key Contact: _____

Address: _____

City: _____Zip Code:_____

Phone: _____

Email: _____

Web Site: _____

PROVIDER INFORMATION

Please list name & email address for the following team members.

	Name	Email
CEO/Executive Director		
Medical Director		
Clinical Manager		
Volunteer Coordinator		
We Honor Veterans Contact		
Other (if desired)		

List ALL cities and counties that you serve:

Counties	Cities

3. Check one: _____ Not-for-profit _____ For- profit

4. Accredited by: Not accredited JCAHO CHAP ACHC Other (please specify):

_____

Palliative Care membership dues - $500 **Additional Palliative Care location dues -** $200

Additional Palliative Care locations (if applicable):

1) _____
2) _____
3) _____

Member/Organization Name: _____

CEO/Hospice Administrator: _____

Local On- Site Key Contact: _____

Address: _____

City: _____Zip Code:_____

Phone: _____

Email: _____

Web Site: _____

Payment Information

Credit Card #: _____ **Expiration Date:**_____

Name on Card: _____ **CVV Code:**_____

Card Billing Address: _____

Check Number: _____

Signature of Person Completing the Form:_____

Signature of person completing this form: _____

Phone:_____ **Date:**_____