

Health Care Providers Council
Membership Application/Renewal Invoice

Name _____

Organization _____

Mailing Address _____

Work Phone _____ Cell Phone _____

email address _____

*Membership Dues are \$50 per calendar year. Membership is for individuals versus businesses and are not transferable. Please make checks payable to HCPC and mail to:

Health Care Providers Council
P.O. Box 64735
University Place, WA 98466

Benefits of Membership Include:

- *Networking opportunities at monthly breakfast meetings and after hours events.
- *Communication via the HCPC monthly electronic newsletter and emails.
- *Participation in HCPC sponsored events and expositions.
- * Opportunities for personal and professional growth via educational events and guest speakers.
- *Professional Referral and Employment opportunities.