CARHC
California Association of Rural Health Clinics

MEMBERSHIP APPLICATION

ORGANIZATIONAL MEMBER INFORMATION
(Please complete a separate form for each clinic.)

Membership category *(Please indicate)*	❑ CARHC clinic membership	❑ Affiliate non-clinic membership

Clinic Name:

Name of Health System or District Affiliation (if applicable):

Name of Hospital or Organization (if applicable):

Clinic or Organization	Physical Street Address:				
	City:	State:	ZIP Code:		County:
	Phone:	Fax:	Email:		Website:
	Mailing Address (if different):				
	City:	State:	ZIP Code:		Clinic CMS Number:
	RHC category (Please check)	❑ Independent	❑ Provider-Based		❑ Affiliate
	Ownership category (Please check)	❑ Nonprofit	❑ For Profit-Corporation		❑ Government-Federal
			❑ For Profit-Partnership		❑ Government-Local
			❑ For Profit-Individual		

Clinics Only:	Annual RHC Encounters:	RHC Certification Year:	# RHC Employees (Not FTE):

Affiliates: Please provide information about your interest in RHCs. (This may be used in your directory listing.)

Member Contacts: Name(s), Emails, and Direct Phone Number. (We encourage multiple contacts in your organization.)
       (Please indicate the primary contact and billing contact.)

ANNUAL DUES

$300	CARHC Member Clinic
$100	Additional clinic Membership (Please complete a separate Membership Application for each additional member, additional clinics must be within the same health system)
$350	Affiliates (Non-Clinic Member)

Payments can be made by logging into your Member's Portal at www.CARHC.org. You may also opt to email this application to Info@CARHC.org and fill out the payment info. Or you may mail your application and payment to **CARHC, Attn: John Angell 590 W. Putnam Ave Porterville, CA 93257** If you have any questions, email to **Info@CARHC.org**

Credit Card Payment: ☐ VISA ☐ MasterCard ☐ Discover ☐ Other

Name On Card:	**Card Number:**
Exp. Date:	**Security Code:**
Billing Address:	

SIGNATURE

Signature of applicant:	Date: