



MEMBERSHIP APPLICATION
For Support Groups

www.nationalperinatal.org

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

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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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
2000 North Beauregard St., 6th Floor
Alexandria, VA 22311**

Comment Section (Please provide comments)

Recent Projects/Successes _____

Recent Challenges/Problems _____

Other Comments _____

Suggestions For NPA _____