



PENNSYLVANIA ASSOCIATION OF COMMUNITY HEALTH CENTERS

**Pennsylvania Association of Community Health Centers
Corporate Membership Application ----- 2016**

Company Name: _____

Contact Person: _____ Title: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: () _____ Fax: () _____

Priority E-mail: _____

Secondary E-mail: _____

Description of products or services offered or may send a promotional brochure (please also send a logo jpg for the PACHC website):

Level of membership:

GOLD (\$5,000)

SILVER (\$3,500)

BRONZE (\$2,000)

Credit Card Type:	<input type="checkbox"/> Visa	<input type="checkbox"/> MasterCard	<input type="checkbox"/> Discover	<input type="checkbox"/> American Express
Name on Card:	_____			
Credit Card No:	_____			
Expiration Date:	_____	Security (CVV) Code:	_____	
Cardholder Signature:	_____			

Please make check payable to Pennsylvania Association of Community Health Centers

1035 Mumma Road, Suite 1, Wormleysburg, PA 17043

Phone: 717-761-6443 Fax: 717-761-8730

pachc@pachc.org - www.pachc.org