



Bucks County Immunization Coalition Membership Application

- Organizational Membership (representative of a larger group in the community)
- Individual Membership (personal interest in the group)
- Community Partner (collaborative support for projects; unable to attend meetings)

Name: _____

Employer: _____

Job Title: _____

Address: _____

Work Phone: _____ Cell Phone: _____

Email address: _____ Fax number: _____

Please check all ways you or your organization would be willing to support the coalition:

| | |
|--|--|
| <input type="checkbox"/> Projects | <input type="checkbox"/> Financial contributions |
| <input type="checkbox"/> Grants / Funding | <input type="checkbox"/> Telephone calls |
| <input type="checkbox"/> Membership | <input type="checkbox"/> Give aways |
| <input type="checkbox"/> Medical Advisor | <input type="checkbox"/> Presentations |
| <input type="checkbox"/> Advertising | <input type="checkbox"/> Consumer Advisor |
| <input type="checkbox"/> Printing | <input type="checkbox"/> Meeting space |
| <input type="checkbox"/> Event planning and or space | <input type="checkbox"/> In-kind services _____ |
| <input type="checkbox"/> Mailings | |

I and the organization that I represent agree with and will uphold the mission of BCIC.

Signature: _____ Date: _____

Please return completed application to Ann Gordon, RN, MSN at 1282 Almshouse Road, Doylestown, PA 18901 or by fax: 215-345-3833 or email: avgordon@co.bucks.pa.us