

# Member Registration Form



**HCPRMS**

HEALTH CARE PR & MARKETING SOCIETY

**Name:** \_\_\_\_\_

**Title:** \_\_\_\_\_

**Organization:** \_\_\_\_\_

**Email:** \_\_\_\_\_

*Please Note: An email is required to receive HCPRMS News & Events updates*

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Cell:** \_\_\_\_\_ **Home:** \_\_\_\_\_

**Website Address:** \_\_\_\_\_

## Type of Organization:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Adult Day Care                       | <input type="checkbox"/> Durable Medical Equipment        | <input type="checkbox"/> Insurance                 |
| <input type="checkbox"/> Advertising & Marketing              | <input type="checkbox"/> Full Spectrum Senior Health Care | <input type="checkbox"/> Managed Care              |
| <input type="checkbox"/> Communications                       | <input type="checkbox"/> Foundation                       | <input type="checkbox"/> Media/Directories         |
| <input type="checkbox"/> Alzheimer's Care                     | <input type="checkbox"/> Group Home                       | <input type="checkbox"/> Public Relations Services |
| <input type="checkbox"/> Assisted Living                      | <input type="checkbox"/> Health Care System               | <input type="checkbox"/> Rehab Services            |
| <input type="checkbox"/> Association                          | <input type="checkbox"/> Home Health Service              | <input type="checkbox"/> Skilled Nursing Facility  |
| <input type="checkbox"/> Clinic                               | <input type="checkbox"/> Hospital                         | <input type="checkbox"/> Other: _____              |
| <input type="checkbox"/> Consultants                          | <input type="checkbox"/> Hospice                          | _____  |
| <input type="checkbox"/> Continuing Care Retirement Community | <input type="checkbox"/> Independent Living               | _____  |

## Additional Members from My Organization:

Name: \_\_\_\_\_ Title: \_\_\_\_\_ Email: \_\_\_\_\_

Name: \_\_\_\_\_ Title: \_\_\_\_\_ Email: \_\_\_\_\_

Name: \_\_\_\_\_ Title: \_\_\_\_\_ Email: \_\_\_\_\_

**Questions, Comments or Suggestions:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The annual membership fee is \$180.00 per member and is good for one year, starting in January. You may join HCPRMS at any time of the year at a prorated fee. Non-members may attend meetings for \$30.

Vicki Henning  
Senior Referrals  
4811 S. 76th Street, Suite 9  
Greenfield, WI 53220-4351

You may also submit this form online at [www.hcprms.org/join.php](http://www.hcprms.org/join.php) and mail payment separately, or bring the completed form with payment to the next HCPRMS event.