

# Member Registration Form



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: \_\_\_\_\_

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The annual membership fee is \$150.00 per member if paid by January 31<sup>st</sup> and is good for one year, starting in January. 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.