

Arizona Public Health Association (AzPHA)
Membership Form
 2920 N. 24th Ave. #4, Phoenix, AZ 85015 • www.azpha.org

Name: First, Last and Suffix/Degree			
Organization Name (if applicable)			
Department			
Street Address			
City, State Zip			
Phone			
Fax			
Primary E-Mail address			
Would you like your name to be included on our public health e-mail news distribution list, which is also known as the AZPHANET listserve?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Home address (optional and if different from above) We use this in case you change employment.			
City, State Zip			
Phone			
Fax			
Secondary E-mail			
TYPE OF MEMBERSHIP			
CHECK ONE	<input type="checkbox"/>	Individual	\$60.00
	<input type="checkbox"/>	Retired	\$25.00
	<input type="checkbox"/>	Student	\$25.00
	<input type="checkbox"/>	Student of Sustaining Agency 1-Diamond, 20% discount	\$20.00
	<input type="checkbox"/>	Student of Sustaining Agency 2-Bronze-Platinum, 15% discount	\$21.00
	<input type="checkbox"/>	Employee of Sustaining Agency 1-Diamond, 20% discount	\$48.00
	<input type="checkbox"/>	Employee of Sustaining Agency 2-Bronze-Platinum, 15% discount	\$51.00
	<input type="checkbox"/>	Sustaining 1-Diamond	\$10,000 +
	<input type="checkbox"/>	Sustaining 2-Platinum	\$5,000 +
	<input type="checkbox"/>	Sustaining 3-Gold	\$2,500 +
<input type="checkbox"/>	Sustaining 4-Silver	\$1,000 +	
<input type="checkbox"/>	Sustaining 5-Bronze	\$500 +	
SECTION – (Areas of interest and/or employment)		Choose from the sections on the left. We will contact you regarding your interest and desire to serve at least one section's activities.	
Environmental Health Epidemiology Gerontology Health Admin, Research & Planning (HARP) Health Disparities Health Education Indigenous Health Injury Prevention Managed Care Mental Health Nursing Nutrition Oral Health School Health		1/Primary - _____ 2 _____ 3 _____ 4 _____	
Arizona State Legislative Voting District			
US Congressional Voting District			
Are you interested in participating in any AzPHA Committees? If yes, check one or more		<input type="checkbox"/> Awards/Scholarship <input type="checkbox"/> Bylaws <input type="checkbox"/> Conference Planning <input type="checkbox"/> Executive <input type="checkbox"/> Fund Development	<input type="checkbox"/> Legislative <input type="checkbox"/> MCH Team <input type="checkbox"/> Membership <input type="checkbox"/> Newsletter <input type="checkbox"/> Nominations
Are you a member of the American Public Health Association (APHA)?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Would you like information about becoming a member of the APHA?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
May we include your name and address on the AzPHA mailing lists provided to other organizations?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
TYPE OF PAYMENT		<input type="checkbox"/> Check enclosed. Make checks payable to AzPHA.	
		Credit Card <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express Card # _____ Expiration Date: _____ 3-digit Security Code: _____	
Send application and payment to the address above.		<i>For Office Use Only</i>	
For additional information: Susan Higgins, Executive Director Tel: 602-258-3361 E-Mail: susan@azpha.org,		Date Received _____ Amount _____	