Individual Membership Application Form
COALITION FOR COMPASSIONATE CARE OF CALIFORNIA

Yes, I want to be a member of the Coalition for Compassionate Care of California!

- ❑ Please accept my $50 individual membership dues
- ❑ I also want to make an additional donation of $_____ today.

My Information:

Name:_____ Title:_____

Company or Organization:_____

Home:

Address: _____

City: _____

State: _____ Zip Code: _____

Email: _____

Phone: _____

Preferred Mailing Address for Renewal Notification:

❑ Work ❑ Home

Work:

Address: _____

Suite: _____

City: _____

State: _____ Zip Code: _____

Email: _____

Phone: _____

Fax: _____

Payment Information:

- ❑ My check is enclosed (made payable to CCCC)
- ❑ Please send me an invoice at (circle one): work home
- ❑ My credit card payment information is below

Name on Card: _____

Credit Card Number:_____

Expiration Date: _____ Security Code: _____ Billing Zip: _____

OR PAY ONLINE TODAY AT
COALITIONCCC.ORG/MEMBERSHIP

Please send this form and your payment information to:

2530 RIVER PLAZA DRIVE, SUITE 110, SACRAMENTO, CALIFORNIA 95833
(916) 489-2222 | MEMBERSHIP@COALITIONCCC.ORG | COALITIONCCC.ORG

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