



MASBHC Membership Application

Name		Date	
Organization		Title	
Address			
City		State	Zip
Phone		Fax	
Email			
Home Address			
City		State	Zip
Phone			

I have enclosed registration fee for:	
<input type="checkbox"/>	Youth / Student Membership - \$0
<input type="checkbox"/>	Individual Membership - \$40.00
	Request to waive dues - Reason _____
Total enclosed with membership application \$ _____	

I am (check all that apply):

- A Student, specify school and county _____
- A Parent, specify school(s) and county _____
- A School clinician/nurse specify school(s) and county _____
- A School administrator/staff, specify and county _____
- A Business professional, specify _____
- Legislator, district _____
- Other, specify _____

I would like to participate in the following committees:

- | | |
|--|--|
| <input type="checkbox"/> Advocacy/Legislative Committee | <input type="checkbox"/> Mental Health Committee |
| <input type="checkbox"/> Finance/Fundraising Committee | <input type="checkbox"/> Nominations Committee |
| <input type="checkbox"/> Training/Technical Assistance Committee | <input type="checkbox"/> Membership Committee |

Make checks payable to:
The Maryland Assembly on School-Based Health Care
 802 Cromwell Park Drive, Suite V, Glen Burnie, MD 21061