MSHCSP

MEMBERSHIP APPLICATION

Membership Fee: $10.00 (covers membership through 6/30/24) Date: _____

Please make check or money order payable to MSHCSP

SEND TO:
MSHCSP
PO Box 20434

Ferndale, MI 48220

New Member ( )
Renewal Membership ( )

MSHCSP Membership #_____
(from membership card)

(PLEASE PRINT LEGIBLE OR TYPE INFORMATION BELOW)

NAME: _____ _____
(First) (Initial) (Last)

Home Address: _____
(Street Address) (Apt #) (City) (State) (Zip Code)

Contact Information: (____) _____ _____
(Telephone #) (E-Mail Address)

EMPLOYMENT INFORMATION:

ORGANIZATION: _____
(Hospital or Healthcare Facility)

Department: _____ Position/Title _____

Address: _____
(Street Address) (City) (State) (Zip Code)

Contact Information: (____) _____ _____
(Telephone #) (E-Mail Address)

Fax Number: (____) _____

My primary contact information is: Home _____ Organization _____

Certification: CBSPD ____ IAHCSMM _____ CST _____ OTHER _____