



California Dialysis Council

MEMBERSHIP APPLICATION

Membership from January 1st - December 31st

Membership Type:

Dialysis Facility \$600.00 Corporate Sponsor \$1000.00 Individual Sponsor* \$100.00

*** NOTE: To be an individual sponsor the individual's facility or corporation must be a member.**

Facility/Organization Name: _____

Individual Name: (for Individual or Corporate Sponsors Only) _____

Address: _____

Telephone #: (_____) Fax #: (_____)

Dialysis Facility Profile:

___ Hospital licensed and based ___ Hospital licensed – Satellite ___ Freestanding
___ Non-profit ___ Profit ___ Single unit ___ Multi-units

Name of Parent Organization: _____

Medical Director: _____

Nursing Supervisor: _____

Administrator: _____

Individual Profile (for individual sponsor only):

___ Physician ___ Administrative/Management ___ Social Worker ___ Dietitian ___ Patient

___ Dialysis Clinical Staff (Please specify): _____

___ Other (Please specify): _____

To whom should emails be sent?: _____

E-mail (please enter e-mail address) _____

**Please return this form with your check, made payable to the
California Dialysis Council
to the Administrative Office at the address below.**