



# California Dialysis Council

## MEMBERSHIP APPLICATION

Membership from January 1<sup>st</sup> - December 31<sup>st</sup>

### 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.**