



California Dialysis Council
CORPORATE MEMBERSHIP APPLICATION

Membership term ~ 12 months from date of payment

Membership Type:

Corporate Sponsor \$1000.00

Organization Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone #: ( ) Fax #: ( )

Primary Contact Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone #: ( ) Fax #: ( )

E-mail Address: \_\_\_\_\_

Which other employees do you wish to receive communications (Reports, News Updates, etc.) ?:

Name: \_\_\_\_\_

E-mail (please enter e-mail address)\_\_\_\_\_

Name: \_\_\_\_\_

E-mail (please enter e-mail address)\_\_\_\_\_

Name: \_\_\_\_\_

E-mail (please enter e-mail address)\_\_\_\_\_

Name: \_\_\_\_\_

E-mail (please enter e-mail address)\_\_\_\_\_

Name: \_\_\_\_\_

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.