P H A

MEMBERSHIP FORM

For membership January 1–December 31, 2018

Make checks payable to *PHA*

MAIL DUES AND DONATIONS TO:
Beverly Austin
PHA (Parent Hospital Association)
2683-17th Avenue
San Francisco, CA 94116

Check which type of membership below.

MEMBERSHIP DUES: ☐ **$25.00 Individual**

☐ **$30.00 Family (individuals with same address)**

If donation included, please indicate the donation amount here: $ _____

PROVIDE THE FOLLOWING INFORMATION FOR PHA ***(Please Print Clearly)***

Name: _____

Address: _____ (Street)

_____ (City/State/Zip)

☐ Check here if this is a new address since 2017

Telephone: _____ Email: _____

Would you consider being on the PHA Board: **Yes** ☐ **No** ☐

Would you consider being on a PHA Committee: **Yes** ☐ **No** ☐

Please check all that apply:

☐ Family Member ☐ Conservator
☐ Former SDC Staff ☐ Other: _____

PHA is a registered non-profit organization