Membership Application

New Membership ☐
Renewal Membership ☐

Name: _____

Company Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Street Address (if different): _____

City: _____ State: _____ Zip: _____

Business Phone: (_____)_____

Cell Phone: (_____)_____

Fax Number: (_____)_____

Email Address: _____

Website: _____

Brief Description of Your Organization's Products or Services *(continue on back, if necessary):*

_____

_____

_____

The Healthcare Network Group of the Lowcountry has four standing committees. Please indicate which ones you would like to be considered for:

Legislative ☐ ***Publicity*** ☐ ***Membership*** ☐ ***Events*** ☐

I have read and I agree to abide by the Healthcare Network Group of the Lowcountry's Code of Ethics. (A copy of the Code of Ethics and/or Bylaws can be obtained by writing to the Membership Chair.)

_____
Signature

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Please send your check for $50 to: ***Healthcare Network Group of the Lowcountry***
P.O. Box 1624
Bluffton, SC 29909.