Membership Application

Name: _____ _____ _____
First M.I. Last

Home Address:_____

City:_____ State: _____ ZIP:_____

Phone: _____ E-mail: _____

Employer/Organization:_____

Employer Address: _____

City:_____ State: _____ ZIP:_____

Please indicate how you learned about the Urban Network Board: _____

Tell us in which areas you are interested in participating in:

____ Event planning/Fundraising

____ Marketing

____ Member Cultivation

____ Community Service

____ Executive Committee Member

____ Other _____

To become a member, please **fill out this application completely** and submit it with a copy of your **current resume** to the Chicago Family Health Center Community Affairs Manager and send to:

ATTN: Valerie Reynolds
Community Affairs Manager
Chicago Family Health Center
9119 S. Exchange Ave.
Chicago, IL 60617
Or E-mail to: vreynolds@chicagofamilyhealth.org

I would like to become a member of Chicago Family Health Center's Urban Network Board and have completed this applications honestly and accurately.

Applicant Signature: _____ Date: ____/____/_____

"Creating Tomorrow's Leaders, Today"

The information contained within this document is privileged and private between Chicago Family Health Center (to be identified further as CFHC),and the Applicant mentioned above, Information contained within this document will not be given to any third party in any way or by any means whatsoever without the express written permission of the applicant, unless circumstances arise that it is a legal requirement to do so, and under these circumstances the applicant will be notified accordingly.