Georgia Public Health Association

Organizational Membership Application

Membership Contact Information

(Please Complete All Sections)

Organization: _____

Contact Person: _____

Address: _____

City/State: _____

Contact Email: _____

Contact Phone: **Contact Fax:** _____

Membership Type

Organizational Member
$250
Includes 5 individual members
(Please provide contact information for each member.)

Payment:

Membership **$ 250.00**

Total Enclosed **$**_____

Submit payment and application to:

GA Public Health Association
2711 Irvin Way, Suite 111
Decatur, GA 30030

OR

Pay by credit card online:
www.gapha.org

Member 1

Name: _____

Title/Organization: _____

Address: _____

Phone: _____ Email: _____

APHA Member? Circle One Yes No

Member 2

Name: _____

Title/Organization: _____

Address: _____

Phone: _____ Email: _____

APHA Member? Circle One Yes No

Member 3

Name: _____

Title/Organization: _____

Address: _____

Phone: _____ Email: _____

APHA Member? Circle One Yes No

Member 4

Name: _____

Title/Organization: _____

Address: _____

Phone: _____ Email: _____

APHA Member? Circle One Yes No

Member 5

Name: _____

Title/Organization: _____

Address: _____

Phone: _____ Email: _____

APHA Member? Circle One Yes No