

Please print clearly

Name (First Name, Middle Initial, Last Name) _____ Credentials _____

Title _____

Representative County _____

I am **NEW** to CCLHDN this year: Yes No

The following is my current contact information:

Address (street number, street name, apartment/suite) _____

City, State, Zip Code _____

() () ()
 Work phone Home phone Fax

Email address _____

Does your agency have other Public Health RD's that will be involved in CCLHDN? Y___ N___
If yes, please complete a separate application for each Public Health RD so CCLHDN has accurate/current contact information. Please note that membership is complimentary for additional county contacts.

**Please complete application with check
 made payable to CCLHDN**

Tax ID# 68-0427712

Send to:

Anaa Reese, CCLHDN Treasurer
 Alameda County
 Public Health Department
 1000 Broadway, Suite 500
 Oakland, CA 94607

NOTE: If County requires a completed W-9,
 please contact Treasurer at:
 (510) 208-5909
 Fax: (510) 208-5932
Email: anaa.reese@acgov.org

MEMBERSHIP DUES

Voting RD Member	\$ 90	_____
Retired RD	\$ 50	_____
Other Professions	\$ 125	_____

DONATIONS

Voluntary contributions to offset some of our expenses are gratefully accepted. Thank you!

Donation Amount Enclosed: \$ _____

Total Amount Enclosed: \$ _____

For office use only:

Check number: _____ Total enclosed: _____ Date rec'd: _____
 Date faxed to membership secretary: _____ Added to directory: _____
 Membership packet sent: _____