

MEMBERSHIP APPLICATION

**To become a member of CSHR, please print, complete and mail this application.
Your membership is appreciated.**

COMPANY NAME _____

CONTACT NAME _____

TITLE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ FAX _____

EMAIL _____ WEBSITE _____

Membership fee: \$1000/year and \$200 per facility owned (2009/2010 pricing)

Please make check payable to CSHR and mail along with this form to:
Coalition for Senior Healthcare Reform
207 Constitution Avenue NE
Washington, DC 20002