MCNP Corporate Sponsorship Application

This application is by and between the MCNP and the organization listed below. The MCNP agrees to provide Corporate Sponsorship Benefits for a term of 1 year as detailed in the MCNP Corporate Sponsorship Structure.

Organization Name: ____

Contact Person: ____ Title: _________________________________

Address: ____

City: ____ State: ____________ Zip: _____________________

Phone: ____ Fax: _______________________________________

E-mail: ____

By completing this application and signing below, the individual attests that they are an authorized representative of the **Corporate Sponsor** organization.

Signature: ____Date: ____________________

Title: _____________________________________

Once your Corporate Sponsorship application has been processed, you will be contacted by the MCNP web editor and asked for a file copy of your organizational logo and summary statement about your company for posting on the MCNP website. You will also be provided with a code for the discounted MCNP membership rate for your APN employees. Upon registration with this code, employment status with your organization will be verified, and membership will be valid for 1 year.

Please email editor@mcnpweb.org or call 781-575-1565 with any questions about Corporate Sponsorship or completing this form. Please make check made payable to **Massachusetts Coalition of Nurse Practitioners** and return with this completed form to:

MCNP
PO Box 1135
Littleton, MA 01460