



**AFFILIATE MEMBERSHIP APPLICATION**

AFFILIATE INFORMATION	
Organization Name	_____
Member Name	_____
Address	_____
	_____
	City _____ Zip _____
Telephone Number	_____
Fax Number	_____
E-mail	_____
Website	_____
Membership Fee	\$ _____ 400.00
Name of Person Completing the Application	_____
Position of Person Completing the Application	_____
Signature of Person Completing the Application	_____
	Date _____
FOR WPHCA STAFF USE ONLY	
WPHCA Membership Representative Signature	_____
	Date _____
Notes:	_____

For more information, please contact Lindsey Hess at [lhess@wphca.org](mailto:lhess@wphca.org) – (608) 277-7477