

MONROVIA PROVIDERS GROUP

Application for Membership 2012

MEMBER INFORMATION

Date: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Name of Organization/Business: _____

Email: _____ Tele: _____ Cell: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Circle Your Credential: MD LCSW MFT CFP RN LVN PT OT ST Other: _____

Please list all licensing and license numbers required to advertise your organization:

To qualify for Active membership, you must have been granted a license to practice as required for your specialty. Application received without appropriate license number will not be processed. Unlicensed recruits must provide a copy of your business license and current certification, if applicable. Please list type of license & corresponding number below:

License: _____ #: _____

License: _____ #: _____

License: _____ #: _____

CIRCLE SERVICE DESCRIPTION:

INDEPENDENT LIVING ASSISTED LIVING BOARD & CARE HOMECARE

HOME HEALTH FINANCIAL SERVICES INSURANCE LEGAL SERVICES

CIVIL SERVICE: _____ Medical: _____ OTHER: _____

ANNUAL DUES:

Please attach a copy of your current business license, professional licenses and/or certifications along with your membership dues.

_____ Membership Application

_____ Copies of Business License is attached

_____ Copies of all applicable Professional Licenses & Certifications are attached

_____ Annual Dues in the amount of \$75.00 is attached

MAIL APPLICATION TO:

Monrovia Community Center - **Monrovia Providers Group**

PO BOX 2068, Monrovia, CA 91017 **Attn: Membership**

Applicant Signature: _____ Date: _____

Receipt Mailed _____ Check #: _____ Cash Paid: _____ Date

Received: _____ MPG Representative / Signature: _____

Date: _____