



2010 MEMBERSHIP APPLICATION - PROVIDER

"Promoting the art and science of hospice and palliative care"

Provider membership in the Utah Hospice & Palliative Care Organization is available to any licensed Hospice program, or other interdisciplinary group providing end of life services in the State of Utah.

Return completed Membership Application(s) with appropriate dues to:

UHP CO ~ 1327 South 900 East ~ Salt Lake City, UT 84105

Provider Name _____

Address _____ Main Office Branch

City _____ State _____ Zip _____

Phone (_____) _____ Fax (_____) _____

Website _____ Toll Free _____

Application completed by _____ Title _____

Counties Served: *(for agency listing on web site)*

- | | | | |
|------------------------------------|-----------------------------------|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Beaver | <input type="checkbox"/> Emery | <input type="checkbox"/> Morgan | <input type="checkbox"/> Summit |
| <input type="checkbox"/> Box Elder | <input type="checkbox"/> Garfield | <input type="checkbox"/> Piute | <input type="checkbox"/> Tooele |
| <input type="checkbox"/> Cache | <input type="checkbox"/> Grand | <input type="checkbox"/> Rich | <input type="checkbox"/> Uintah |
| <input type="checkbox"/> Carbon | <input type="checkbox"/> Iron | <input type="checkbox"/> Salt Lake | <input type="checkbox"/> Utah |
| <input type="checkbox"/> Daggett | <input type="checkbox"/> Juab | <input type="checkbox"/> San Juan | <input type="checkbox"/> Wasatch |
| <input type="checkbox"/> Davis | <input type="checkbox"/> Kane | <input type="checkbox"/> Sanpete | <input type="checkbox"/> Washington |
| <input type="checkbox"/> Duchesne | <input type="checkbox"/> Millard | <input type="checkbox"/> Sevier | <input type="checkbox"/> Wayne |
| | | <input type="checkbox"/> Weber | |

Written Communication

E-mail is the preferred method of communication and correspondence will be sent to the Administrator and the Director of Nursing as listed below. Medical Directors will be contacted as needed. Others from your agency who wish to be included as contacts are encouraged to join UHP CO as Individual members.

ADM/CEO _____

E-Mail _____

DON _____

E-Mail _____

Med Dir _____

E-Mail _____

Standing Committee

Please indicate below the committee on which a member of your agency has an interest and will serve. Responsibilities are found in the UHP CO Bylaws.

- | | | |
|---|---|---|
| <input type="checkbox"/> Education | <input type="checkbox"/> Ethics | <input type="checkbox"/> Governmental Affairs |
| <input type="checkbox"/> Membership/Nominating/Awards | <input type="checkbox"/> Public Relations | |

Name _____

E-Mail _____

Voting Representative

The Voting Representative shall be considered the Administrator and the Alternate Voting Representative shall be considered the Director of Nursing... UNLESS SPECIFIED BELOW. Please note: alternate voting representative effective only in absence of voting representative.

Name _____

E-Mail _____

Alternate Name _____

E-Mail _____

Fee Schedule

- One Office Location..... \$ 250.00
- Two Office Locations..... \$ 350.00
- Three or more Locations..... \$ 500.00

Payment Information

- Check enclosed - Make check payable to: **UHP CO**
- Check in Mail
- Credit Card – 3% processing fee will be added
 - American Express
 - Discover Card
 - MasterCard
 - Visa

Exp. Date _____/_____/_____

Card No. _____

Name on Card _____

Zip Code (if different from above) _____

Signature _____

TOTAL DUE \$ _____