NEVADA HEALTH PROFESSIONALS NETWORK

Membership Form

JOIN THE PREMIER HEALTHCARE ORGANIZATION IN NEVADA

Membership is open to all healthcare professionals/organizations/businesses to include but not limited to medical providers of all levels, mental health providers of all levels, first responders, health groups, healthcare related businesses, healthcare educational institutions, and all community partners supporting Nevada healthcare.

All members will have access to NHPN events, continuing education opportunities, professional development opportunities, and exclusive organizational benefits. Corporate sponsors will have additional benefits of being featured in NHPN publications, newsletters, websites, social media, and events.

Contact Information

Company Name (If any): _____

Title: (Mr. Ms. Mrs. Dr. Prof.) _____ Credentials (MD, DO, NP, RN, PA, etc.) _____

First Name_____ Last Name_____

Address _____

City _____ State _____ Zip _____

Office Phone _____ Cell Phone_____

Email _____

Website _____

Brief Description of Your Business:

Membership Levels: Please Select One

- ☐ Health Professionals in Training: Free
  (Must register with institutional email and renew yearly)
- ☐ Businesses with 1 to 25 Employees: $400 / year
- ☐ Corporate Partners: $2,000 / year
- ☐ Individual and Business Professionals: $99 / year
- ☐ Business with 26 to 100 Employees: $1,000 / year

Sponsorship: $ _____

Terms and Conditions:

All membership shall be automatically renewed annually unless cancelled in writing by member OR by Nevada Health Professionals Network for non-payment of dues OR due to non-compliance with Nevada Health Professionals Network policies. Membership dues are non-refundable. By providing your e-mail address you hereby consent to receive communications from the Nevada Health Professionals Network and its affiliates.

Applicant's Signature: _____ **Date:** _____

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Membership Form

Credit Card Authorization Form

Name: _____

Billing Street Address: _____

City: _____ State: _____ Postal Code: _____

Email _____

Direct Telephone: (____) _____-_____

PAYMENT INFORMATION

Credit Card Type:

☐ MasterCard
☐ Visa
☐ American Express
☐ Discover Card

Credit Card Number: _____

Expiration Month: _____ Expiration Year: _____

Cardholder Signature X _____ Date _____/____/_____

Security Code: _____

Check
☐ Pay by check:

Checks should be made out to: Nevada Health Professionals Network
Mail to: 3667 Dutch Valley Dr, Las Vegas, NV 89147