IndianaCareCircle (ICC)

(formerly North Central Indiana Continuity of Care)

I.C.C.
MEMBERSHIP APPLICATION

Agency/Affiliation: _____Date:_____
Name: _____
Business Address:_____
Business Phone: _____Ext._____Fax:_____
Job Position: _____
Email_____URL_____

Please give a brief description of your business

_____
_____

Please explain areas of interest that will contribute to the mission and goals of ICC_____
_____

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Corporate Membership
Name: Position: Email Address:

_____
_____

Other attendees

_____
_____

Applications submitted for review to the Membership Committee. You will be notified upon approval.

ICC (make check payable to ICC)
Attention: Membership Committee
P.O. Box 4984
Lafayette, IN 47903

Membership Annual Fee*:*	
Individual	$40.00
Corporate	$50.00

☐ I have read the ICC mission statement and understand the goals as well as the purpose of ICC. I understand ICC is a supportive network in providing educational resources for both the group and the Lafayette community to enhance continuity of care.

_____
Name(signature) Date

Approved by Executive Committee on the ____day of _____, 20__.