



**MSHCSP
MEMBERSHIP APPLICATION**

Membership Fee: \$10.00 (covers membership through 6/30/11) Date: _____
Please make check or money order payable to MSHCSP

SEND TO:

**Wilma Wilder
16241 W. 9 Mile Rd.
#101
Southfield, MI 48075
Fax: 248-200-3220
Wilma.Wilder@stjohn.org**

New Member ()
Renewal Membership ()

MSHCSP Membership # _____
(from membership card)

(PLEASE PRINT OR TYPE INFORMATION BELOW)

NAME: _____
(First) (Initial) (Last)

Home Address: _____
(Street Address) (Apt #) (City) (State) (Zip Code)

Contact Information: (____) _____
(Telephone #) (E-Mail Address)

EMPLOYMENT INFORMATION:

ORGANIZATION: _____
(Hospital or Healthcare Facility)

Department: _____ Position/Title _____

Address: _____
(Street Address) (City) (County) (State) (Zip Code)

Contact Information: (____) _____
(Telephone #) (E-Mail Address)

Fax Number: (____) _____

My primary contact information is: Home _____ Organization _____

Certification: CBSPD ____ IAHCSPM ____ CST ____ OTHER ____