Hawai`i Public Health Association

Promoting public health in Hawai`i through leadership, collaboration, education and advocacy.

HPHA Organizational Membership Form Hibiscus Level	
Applicant Information	
Organization Name:	
Address:	
Membership Rate: ☐ $500 Hibiscus Level 11-100 employees/includes 5 individual memberships	
**Please make dues payable to Hawai`i Public Health Association and send to:** Hawai`i Public Health Association 7192 Kalanianaole Hwy, Suite A143A #226 Honolulu, Hawai'i 96825-1832	
Please list contact information below for employees who will be listed as individual HPHA members:	
Dr. ☐ **Mr.** ☐ **Ms.** ☐ **Mrs.** ☐ **Other** ☐	**Degree(s):**
Name:	
Title or Position:	
Email:	
Phone:	**Cell:**
Dr. ☐ **Mr.** ☐ **Ms.** ☐ **Mrs.** ☐ **Other** ☐	**Degree(s):**
Name:	
Title or Position:	
Email:	
Phone:	**Cell:**

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Dr. ☐ **Mr.** ☐ **Ms.** ☐ **Mrs.** ☐ **Other** ☐	**Degree(s):**
Name:	
Title or Position:	
Email:	
Phone:	**Cell:**
Dr. ☐ **Mr.** ☐ **Ms.** ☐ **Mrs.** ☐ **Other** ☐	**Degree(s):**
Name:	
Title or Position:	
Email:	
Phone:	**Cell:**
Dr. ☐ **Mr.** ☐ **Ms.** ☐ **Mrs.** ☐ **Other** ☐	**Degree(s):**
Name:	
Title or Position:	
Email:	
Phone:	**Cell:**
Signature of Applicant:	***Date:***