Hawai`i Public Health Association

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

HPHA Organizational Membership Form
Maile Level

Applicant Information

Organization Name:

Address:

Membership Rate: ☐ $1,000 Maile Level
11-100 employees/includes 10 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:**

<table>
<tr><td colspan="2">Dr. ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Other ☐</td><td>Degree(s):</td></tr>
<tr><td colspan="3">Name:</td></tr>
<tr><td colspan="3">Title or Position:</td></tr>
<tr><td colspan="3">Email:</td></tr>
<tr><td>Phone:</td><td colspan="2">Cell:</td></tr>
<tr><td colspan="2">Dr. ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Other ☐</td><td>Degree(s):</td></tr>
<tr><td colspan="3">Name:</td></tr>
<tr><td colspan="3">Title or Position:</td></tr>
<tr><td colspan="3">Email:</td></tr>
<tr><td>Phone:</td><td colspan="2">Cell:</td></tr>
<tr><td colspan="2">Dr. ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Other ☐</td><td>Degree(s):</td></tr>
<tr><td colspan="3">Name:</td></tr>
<tr><td colspan="3">Title or Position:</td></tr>
<tr><td colspan="3">Email:</td></tr>
<tr><td>Phone:</td><td colspan="2">Cell:</td></tr>
<tr><td colspan="2">Signature of Applicant:</td><td>Date:</td></tr>
</table>