



THE ALLIANCE OF COMMUNITY SERVICE PROVIDERS

ASSOCIATE MEMBER APPLICATION FORM

NAME OF ORGANIZATION: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP+4: _____

PHONE: _____ FAX: _____ E-MAIL: _____

CEO/EXECUTIVE DIRECTOR: _____

PRIMARY CONTACT PERSON: _____

(who will represent your organization at The Alliance meetings and receive ongoing correspondence.)

ADDRESS: _____

CITY: _____ STATE: _____ ZIP+4: _____

PHONE: _____ FAX: _____ E-MAIL: _____

Please provide The Alliance with company brochures or other associated publications

NATURE OF BUSINESS/SERVICES:

REFERRING ALLIANCE (Regular) MEMBER(S): _____

(IF MORE THAN ONE, PLEASE LIST ALL.)

KINDLY COMPLETE-- Briefly, why are you interested in joining The Alliance:
