



**MAIWHC**

# Montana American Indian Women's Health Coalition Membership Form

I AM INTERESTED IN SERVING ON MAIWHC:

I RECOMMEND THE FOLLOWING BE INVITED TO SERVE ON MAIWHC:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Credentials: \_\_\_\_\_ Salutations: \_\_\_\_\_ Site: \_\_\_\_\_

Job Title: \_\_\_\_\_ Organization: \_\_\_\_\_

Mailing address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_ Alt Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

I AM NO LONGER INTERESTED IN SERVING ON MAIWHC:

Reason for resigning: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### For Office Use Only

Change      New Entry

Requested by: \_\_\_\_\_ Manager Approval: \_\_\_\_\_

Requested on date: \_\_\_\_\_ Date done: \_\_\_\_\_

Comments: \_\_\_\_\_ Relation to Section: \_\_\_\_\_

Groups to add:

IHS Billings Area Office

MAIWHC

MCCP Contractors/Liaisons

MCCP Site Staff

MCCP Subcontractors

Misc

Surveillance Reports

Vendor