

ORGANIZATION NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_

STATE \_\_\_\_\_

ZIP \_\_\_\_\_

( ) \_\_\_\_\_

( ) \_\_\_\_\_

BUSINESS TELEPHONE \_\_\_\_\_

BUSINESS FAX \_\_\_\_\_

PLEASE DESIGNATE PERSON TO REPRESENT ORGANIZATION AND RECEIVE ALL MEMBERSHIP BENEFITS

NAME \_\_\_\_\_

TITLE \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

ORGANIZATIONAL MEMBERSHIP FEE

\$500

\_\_\_\_\_

Optional

Journal of School Health

\$75

\_\_\_\_\_

Publisher: American School Health Assn.

TOTAL

\$

\_\_\_\_\_

SUBMIT FORM TO:

NASBHC

1100 G Street, NW, Suite 735

Washington, DC 20005

FAX (202) 638-5879

**PAYMENT INFORMATION**

Federal ID Number: 54-1752058

Check Enclosed (payable to NASBHC)

Purchase Order (attach copy)

Credit Card Information:

American Express

Discover

MasterCard

Visa

Name on Card \_\_\_\_\_

Card# \_\_\_\_\_

Exp Date: \_\_\_\_ / \_\_\_\_

Security Code: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City/State/Zip \_\_\_\_\_