



Application for Organization Membership

Thank you for your interest in becoming a part of the Society for Participatory Medicine. Any organization that is interested in joining us is welcomed to apply.

Organization Name: _____

Contact Name: _____

Address: _____

City: _____

State/Province: _____

ZIP / Postal Code: _____ Country: _____

Telephone: _____

Email address: _____

Reason for joining the Society:

Choose your one-year Organizational Membership level of support:

- Gold Member - \$20,000
- Silver Member - \$10,000
- Bronze Member - \$5,000
- \$250 – Innovator Organizations
(Must have 5 or fewer full-time employees OR less than \$500,000 in annual revenues to apply to this category)

Please make your check or money order payable to: **The Society for Participatory Medicine**

Please mail to: The Society for Participatory Medicine
PO Box 1183
Newburyport, MA 01950-1183