



Healthy Start Coalition of Sarasota County
General Membership
Individual Voting Member

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE: _____ E-MAIL: _____

NEW MEMBERS: Please complete.¹

Gender: Male Female

Race: White Black Am Indian Asian Other

Ethnic Group:

Hispanic Non-Hispanic Other _____

I represent:

Migrant and Community Health Center; County Health Dept; Birthing Facility;

Maternal or Infant Care Provider; Medical Society; Health Advocacy Interest Group;

Local Health Planning Organization; County or Municipal Government;

Social Service Organization; Education; Consumer of family planning, primary care or prenatal care services; Other: _____

RENEWING MEMBERS: Please complete.

I will renew my membership in the Healthy Start Coalition of Sarasota County for 2009.

I will not renew my membership in the Healthy Start Coalition of Sarasota County for 2009.

If no, please explain why: _____

I agree to comply with the provisions of all statutes relative to Healthy Start Coalition membership and participation. I agree to the responsibilities and obligations therein.

DATE: _____ (mo/day/yr) SIGNATURE: _____

¹ In keeping with 10D-113.005 of 383.216(10) F S. which states in part, "each coalition shall represent health care providers, the recipient community, and the community at large; shall represent the racial ethnic and gender composition of the community."