NACHC
Certificate in Health Center Governance Program

ENROLLMENT FORM

Name: _____ Title: _____

Health Center Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

E-Mail: _____ IMIS ID _____
We must have a unique email address for your account *(Your badge #)*

I wish to receive all correspondence related to the Certificate In Health Center Governance Program:

❏ at the above address

❏ at the following address:

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

E-Mail: _____

The Certificate Program enrollment fee of $25.00 is waived for individuals who serve on the board of a health center which is a NACHC Organizational Member in good standing.

❏ My health center is not a NACHC Organizational Member, therefore, my enrollment fee is enclosed in the amount of $25.00.

_____ _____
Signature Date

For NACHC use only:

Date received _____

Organizational Member in Good Standing: _____Yes _____No

Application Fee: _____ waived, _____ enclosed amount: $ _____