



# CHPRMS Membership Form

To join the society, mail your check (**payable to the Carolinas Healthcare Public Relations and Marketing Society**), a copy of this form, and a black and white photograph of yourself (preferably a 5 X 7) to the address below. Or e-mail a digital image to the e-mail address listed below.

-----**Personal Information**-----

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

Maiden Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (     ) \_\_\_\_\_

-----**Business Information**-----

Current Employer: \_\_\_\_\_

Type of Business: \_\_\_\_\_

Position/Title: \_\_\_\_\_

Name and Title of Your CEO: \_\_\_\_\_

Business Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Business Phone: (     ) \_\_\_\_\_

-----**Other Information**-----

E-mail address: \_\_\_\_\_

How did you hear about CHPRMS? \_\_\_\_\_

Please list other professional associations/groups for which you are a member: \_\_\_\_\_

\_\_\_\_\_

Send correspondences to:     Home     Business

-----**Dues Information**-----

Active Members: Annual dues are **\$50** for each member.

**MEMBERSHIP CHAIR**

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