



NATIONAL HAITIAN AMERICAN HEALTH ALLIANCE
A community response to health disparities

Company Name:		
Contact Name:		Title:
Mailing Address:		
City:	State:	Zip Code:
Phone:		Fax:
Website:		Email:
Area of Interest:		
Area of Expertise:		

Individual	Organizational		Affiliates
	Annual Revenue and Budget		<input type="checkbox"/> Institutional fee plus \$100
<input type="checkbox"/> Associate	\$0	<input type="checkbox"/> Less than \$ 100,000 \$ 100	
<input type="checkbox"/> Full Member	\$50	<input type="checkbox"/> \$100,000 to < \$500,000 \$150	
		<input type="checkbox"/> \$500,000 and over \$ 200	
		<input type="checkbox"/> \$1 million and up \$500	

Enclosed is my contribution of \$ _____ (Please make check payable to NHAHA)

Authorized Signature _____ Date _____

Send completed form to: NHAHA/C/O DCS: 464-466 Bergen Street Brooklyn, NY 11217