Coastal Wellness Collective
P.O. Box 2971, Westerly, RI 02891
Group Membership Registration 2017

Date _____ Group Name: _____

Business Website: _____

Providers Names and Credentials: _____
(Add more on back if needed)

_____

_____

Contact Information: Contact Name: _____
(Add more on back if needed)

Business #1 Address: _____

Business #1 Phone: _____ FAX #: _____

Business #2 Address: _____

Business #2 Phone: _____ FAX #: _____

Work Email: _____

MEMBERSHIP REQUIREMENTS

Membership Fees - Payable to: *Coastal Wellness Collective*

Jan 1 - May 31 - $150
June 1 - Dec 31 - $ 75

I hereby attest that all providers have an active state license to practice locally, and active professional liability insurance. Should either change, I will notify CWC within 30 days of such change.

_____
Authorized Signature of Group Representative

Office Use Only

Date Received _____ Check Name _____

Processed by _____ Check # & Amount_____

Updated: 10/2016