

**Coastal Wellness Collective, P.O. Box 2971, Westerly, RI 02891**  
**Individual Membership Application 2017**

Date \_\_\_\_\_

Provider Name: \_\_\_\_\_ Credentials: \_\_\_\_\_

Business Name: \_\_\_\_\_

Business Website: \_\_\_\_\_

Addresses:

Mailing Address \_\_\_\_\_

Business #1: \_\_\_\_\_

Business #2: \_\_\_\_\_

Business #3: \_\_\_\_\_

Telephone numbers:

Home: \_\_\_\_\_ Business: \_\_\_\_\_

Cell: \_\_\_\_\_ Bus. FAX: \_\_\_\_\_

Work Email: \_\_\_\_\_

**MEMBERSHIP REQUIREMENTS**  
**2017 Membership Fees - Payable to: *Coastal Wellness Collective***

Jan 1 - May 31 - \$100

June 1 - Dec 31 - \$50

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

\_\_\_\_\_  
Signature

**Office Use Only**

Date Received \_\_\_\_\_

Check Name \_\_\_\_\_

Processed by \_\_\_\_\_

Check # & Amount \_\_\_\_\_