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

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_____

Updated: 10/2016