

Associate Type J Care Center Membership Application

Facility _____

Administrator _____

Address _____

City _____ State _____ Zip+4 _____

Phone _____ Fax _____

E-mail _____

Web site _____

County _____

Bed Information:

_____ Active Beds _____ Beds on layaway _____ Rehab

_____ Dementia _____ Hospice _____ **TOTAL BEDS**

Notes:

Director of Nursing:

Name

E-mail _____

Other contacts from your organization:

1) _____
Name Title
E-mail _____

2) _____
Name Title
E-mail _____

How did you hear about Aging Services?

What are your primary interests in Aging Services membership?

I understand that membership is conditional upon approval by the Aging Services of Minnesota Board of Directors and that before becoming a member I must remit the necessary dues.

Signed _____ Date _____

This category of membership provides the same privileges of voting membership, excluding the ability to vote, hold office or serve as a Director.

FOR AGING SERVICES USE

Application/Dues Received _____

Dues Payment Processed _____

Application Processed _____

METHOD OF PAYMENT

Amount _____

Check # _____
Make checks payable to Aging Services of MN

Card # _____

Exp. Date _____

Name on Card

X _____

Cardholder Signature



Please submit application and dues to:

Aging Services of Minnesota
2550 University Avenue West, Suite 350-South
Saint Paul, MN 55114-1900
651.645.0002 (FAX)