



Mother & Child Health Coalition Annual Individual Membership Application

Annual Individual Dues of \$25: New Renewing

Additional donation: \$25 \$50 \$100 Other _____ TOTAL ENCLOSED: _____

Make checks payable to: MCHC

Your tax deductible donation is greatly appreciated. If you have already paid your dues for this year, please pass this on to a colleague.

Name _____

Organization _____ Title _____

Address _____ Is this a home or work address? _____

City _____ State _____ Zip _____

Work phone _____ Fax _____

Home phone _____ E-mail _____

Choose the committee(s) or group(s) about which you would like more information:

- Breastfeeding Childhood Obesity Prevention Fetal Infant Mortality Review Immunization
 Injury Prevention Legislative Pregnancy, Infant and Child Health Adolescent Health

For federal grant reporting purposes, please indicate what ethnicity you consider yourself:

- Asian American Hawaiian/Pacific Islander American Other
 African American Latino American
 Caucasian American Native American

Gender: Female Male Age (optional) _____

How did you hear about us? _____

This is a TRIBUTE gift

Please inform individual(s):

Name: _____

Address: _____

City: _____ ST: _____ Zip: _____

that a gift to *Mother & Child Health Coalition* has been made

- in memory/honor of _____
 on the occasion of _____

Name(s) to appear on card: _____

I'd like information about naming MCHC in my will.

My employer, _____ has a Matching Gift Program.

Company Contact: _____ Phone: _____

For more information, please contact the Coalition at (816) 283-6242 fax (816) 283-0307 or E-mail: info@mchc.net

To pay by credit card, visit our Website at <http://www.mchc.net>

or you can mail the application with your check to MCHC, 6400 Prospect Ave., Suite 216, Kansas City, MO 64132