



COLORADO CONSUMER HEALTH INITIATIVE PARTNERSHIP APPLICATION

To become a partner of the Colorado Consumer Health Initiative, please fill out this form and fax or mail it to the address at the bottom of the page.

INDIVIDUAL PARTNERS:

Home Contact Information (required so we can match you to your elected officials if you want to receive action alerts).

Name:
Home Street Address:
City, State, Zip:
Home Phone (optional):
Primary E-mail Address:

ORGANIZATIONAL PARTNERS ONLY:

Main organizational contact (if other than yourself):
Organization:
Title:
Work Street Address:
City, State, Zip:
Work Phone:
Work E-mail Address:
Mission Statement (please write or attach, if applicable):

SUBSCRIPTIONS:

Health Care Action Network—this important tool will allow you to easily communicate with your elected officials on health policy issues. We will send e-mail action alerts when we want you to take action on a specific piece of legislation or health policy issue. You will also receive bi-weekly e-mail updates to help you stay informed about current health care policy issues. Your home address is required for participation in policy action alerts. You will be automatically added to this subscription list unless you choose to opt out by checking the box below.

Please check this box if you do not want to subscribe to the Health Care Action Network.

VOLUNTEER OPPORTUNITIES

Please check this box if you would like to be contacted about volunteer opportunities.

PARTNERSHIP AGREEMENT:

By signing below, I agree to become a partner of the Colorado Consumer Health Initiative (CCHI). I authorize CCHI to list my name and/or my organization’s name on its partnership list, including its website.

Signature

Date