Georgia Public Health Association

BOH Membership Application/Renewal

Membership Contact Information

(Please Complete All Sections)

BOH:

Contact Person:

Address:

City/State:

Contact Email:

Phone: **Fax:**

Membership Type

BOH Member
$260
Includes 7 Board members
(Please provide contact information for each member.)

Payment:

Membership Fee **$ 260.00**

Submit payment and application to:

GA Public Health Association
2711 Irvin Way, Suite 111
Decatur, GA 30030

OR
Pay by credit card online: www.gapha.org

Member 1

Name: ____________________

Title/Organization: ____________________

Address: ____________________

Phone: ____________________ Email: ____________________

APHA Member? (Circle One) Yes No

Member 2

Name: ____

Title/Organization: ____

Address: ____

Phone: ______________________ Email: ______________________

APHA Member? (Circle One) Yes No

Member 3

Name: ____

Title/Organization: ____

Address: ____

Phone: ______________________ Email: ______________________

APHA Member? (Circle One) Yes No

Member 4

Name: ____

Title/Organization: ____

Address: ____

Phone: ______________________ Email: ______________________

APHA Member? (Circle One) Yes No

Member 5
Name: ____

Title/Organization: ____

Address: ____

Phone: ______________________ Email: ______________________

APHA Member? (Circle One) Yes No

Member 6
Name: ____

Title/Organization: ____

Address: ____

Phone: ______________________ Email: ______________________

APHA Member? (Circle One) Yes No

Member 7
Name: ____

Title/Organization: ____

Address: ____

Phone: ______________________ Email: ______________________

APHA Member? (Circle One) Yes No