CAMHPRA Membership Application

Name: _____

Email Address: _____

Phone Number(s): _____

___ I am a Title 9 Patients' Rights Advocate

County/Counties: _____

___ Other membership status

(See CAMHPRA bylaws Article IV, Sec. 1 B)

Describe: _____

Signature: _____ Date: _____

Organization Use

Regional Coalition:

Membership Paid Date: Check Number: