

HUDSON PERINATAL CONSORTIUM, INC.

Declaration of Membership

NAME: _____
(please print)

TITLE: _____

ORGANIZATION: _____
(if applicable, please print)

ADDRESS: _____

PHONE: _____

FAX: _____

E - MAIL ADDRESS: _____

*Please express your interest in serving on one of the
Committees below:*

Clinical _____ Breastfeeding _____
Nominating/Membership _____
Access to Care _____
Perinatal Addictions _____
Fetal/Infant Mortality Review _____

*As a member of the Hudson Perinatal Consortium, Inc., I will actively
support the purposes and goals of the corporation.*

Signature: _____

Date: _____

*** There is an annual membership fee of \$20.00. Please
make checks payable to Hudson Perinatal Consortium, Inc.**