ASSOCIATE MEMBERSHIP APPLICATION

► CONTACT INFORMATION

Organization: _____

_____

(Include name of any parent organization)

Mailing Address: _____

_____

Physical Address: _____

_____

Website: _____

General Business Phone: _____
General Business Email: _____

SOCIAL MEDIA

Twitter: _____

Facebook: _____

► MEMBERSHIP REPRESENTATIVES

Principal Representative to Mental Health America will be:

Name: _____ Title: _____

Phone: _____ Email: _____

Secondary contact:

Name: _____ Title: _____

Phone: _____ Email: _____

► TYPE OF ORGANIZATION

_____ Business
_____ Government Agency
_____ Nonprofit / Foundation
_____ Academic Institution
_____ Mental Health Services Provider
_____ Peer Run Organization
_____ Consultant Agency
_____ Research or Training Organization

Provide a description of your organization (no more than 50 words).

_____
_____
_____
_____
_____
_____
_____
_____

If application is approved, MHA will require an appropriate high-resolution logo, link, and will pull from your provided description for website content.

Please check the following:

_____ My Associate Membership is not complete until I receive final approval from MHA.

_____ My organization subscribes to MHA's mission which promotes mental health as a critical part of overall wellness, including prevention services for all, early identification and intervention for those at risk, integrated care and treatment for those who need it--with recovery as the goal.

_____ I understand that Associate Membership does not entitle my organization to vote for MHA Board Members.

_____ I can put the Associate Member logo on my website in a place that shows support for MHA without implying endorsement without prior approval from MHA.

_____ I may use the Associate Member logo in email blasts referencing my organization's support of MHA.

_____ If I want to put the Associate Member logo on my letterhead, printed materials, or any commercial products, I must first seek the permission of MHA.

_____ MHA will not use my organization’s name/logo except in the Associate Member listing on their website, unless they have my explicit permission.

_____ I understand that if my organization or I do something that impacts MHA negatively, MHA may cancel our membership benefits without returning payment.

_____ I understand that this is a charitable contribution to MHA and everything is tax-deductible, less an estimated $175 for goods and services.

► **MEMBERSHIP TERMS:**

Your membership is good for 1 year after MHA's approval.

► **MEMBERSHIP DUES PAYMENT:** **____ $500 (US) nonprofit**
____ $1000 (US) for profit

____ Check enclosed.

____ Credit card payment (indicate Visa _____ MasterCard ____ American Express ____)

Name on Card _____

Card # _____ Expiration (mo/yr) _____

Associate Membership applications will be reviewed, and must be approved, by MHA's President & CEO. An invoice is available upon request.

► **SUBMITTED BY:**

Name: _____ Title: _____

Signature: _____ Date: _____

Please submit completed form via regular mail or email to:

AMERICA PAREDES, MS
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