**Membership Agreement**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** agrees to participate in the

**Name of Facility/Organization**

Southeast Regional Healthcare Coalition as a(n)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**facility.

**Agency Type/Affiliation**

By signing below, we affirm our compliance with the regulations and procedures set forth in the Southeast Regional Healthcare By-Laws.

Additionally, we *(please check ONE)*

***DO*** consent to being photographed, videotaped and/or audio recorded by the Southeast Regional Healthcare Coalition (SERHC) and its authorized representatives to be used in promotional material including but not limited to the SERHC website and other social media websites.

Do ***NOT*** consent to being photographed, videotaped and/or audio recorded by the Southeast Regional Healthcare Coalition and its authorized representatives to be used in promotional material including but not limited to the SERHC website and other social media websites.

Signature Title Date

**Organization’s Contact Information**

|  |  |  |
| --- | --- | --- |
| **Address** | **Main Phone #** | **Satellite Phone #** |
|  |  |  |
| **Command Center Phone #** | **Command Center Fax #** | **Command Center Email** |
|  |  |  |
| **Primary Representative** | | |
| **Name** | **Title** | **Office Phone Number** |
|  |  |  |
| **Work Mobile Number** | **Email Address** | **Fax Number** |
|  |  |  |

**Alternate Representative**

|  |  |  |
| --- | --- | --- |
| **Name** | **Title** | **Office Phone Number** |
|  |  |  |
| **Work Mobile Number** | **Email Address** | **Fax Number** |
|  |  |  |