



Moreland Community Health Service Inc.

Membership Application

MORELAND COMMUNITY HEALTH SERVICE INCORPORATED

I, _____
(name)

of _____ (address)

wish to become a member of Moreland Community Health Service Incorporated.
I certify that I am over 18 years of age.

Date : _____

Signature of Applicant : _____

Please note: Membership is valid until you inform us you no longer wish to be a member or until such time that mail sent to you is returned to us.

Office Use Only

Date Received: _____

Signature for the Service : _____