California State Care Providers Association Associate Membership Form (Please Print)

Name(s): _____

_____

Address City Zip Code

Telephone: _(_____)_____ County:_____

e-mail: _____

Areas Of Expertise:

_____

_____

_____

Committees you would like to serve on:

_____

_____

_____

FEE: $35 per person

Please mail this form with a check to:

CSCPA
P.O. Box 4776
Chatsworth, CA 91313