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

Date _______________

Association Name ____ Chapter Number _______

Address ____ City _____________________________

County ___________________________________ Phone _______________ State _____ Zip _____

Chapter Employee Identification Number ____

THIS MUST BE COMPLETED

President _______________________________________ Phone (______)_________________

Address __________________________________ City _______________________ Zip ________

Vice-President _______________________________________ Phone (______)_________________

Address __________________________________ City _______________________ Zip ________

Secretary _______________________________________ Phone (______)_________________

Address __________________________________ City _______________________ Zip ________

Treasurer _______________________________________ Phone (______)_________________

Address __________________________________ City _______________________ Zip ________

Membership Chair _______________________________________ Phone (______)_________________

Address __________________________________ City _______________________ Zip ________

CHAPTER DUES AND INCOME TAX INFORMATION

_____ AFFILIATE CHAPTER: Dues $25.00 An association that operated under its own Nonprofit Status. CALIF ORGANIZATION NUMBER __________________.

_____SUBORDINATE CHAPTER: Dues $50.00 An association that operates under the California Caregivers Association Nonprofit Status. Subordinate Chapters are responsible to send SEMI-

ANNUAl REPORTS to CSCPA. Copies of all Financial Contracts, Grants, Fund raising Reports, Tax letters and Tax Reports.

The signatures below signify affirmation in regard to this Chapter's Income Tax Status.

____ ____

PRESIDENT TREASURER

Member dues: $10.00 per individual

Please send this form with a check to: Mail to: CSCPA, P.O. Box 4776, Chatsworth, CA 91313

Please include a TYPED roster of paid members: Name, address, city, zip, phone + area code