Membership Form

First Name | Middle Name

Last Name

Credentials

Organization

Work Address

City | State | Zip

Work Phone | Cell Phone

Email address

Alternative email address

Website

Home Address

City | State | Zip

Please indicate which organizational groups you belong to:

____Government (Health Department, Department of Human Services, County, City)

____Community (Local community health, community based-clinic, faith-based, business.

____Education (School Administrator, School Nurse, PTA, etc.)

____Provider (Dentist, Hygienist, Physician, Dental Therapist, etc.)

____Public (Foundations, Consumer Advocate, Organizations, etc.)

____Policy (State and federal legislature, policy advocate, policy makers, etc.)

____Health Plans/Third-Party Payer (Managed care, insurance, MN health care plans, etc.)

____Higher Education/Professional Education (University, medical, dental, hygiene, dental therapy, nursing, allied health)

I am interested in volunteering with the Minnesota Oral Health Coalition. My interests are in the area(s) of:

_____Communications

_____Membership

_____Advocacy

_____Development & Fundraising

_____Serving as a board member

_____Other (explain)

Please enroll me as a member of the Minnesota Oral Health Coalition: Initial Here

Send to the Minnesota Oral Health Coalition