Coastal Wellness Collective
P.O. Box 2971, Westerly, RI 02891

Group Membership Registration, Year _____

Date _____ Group Name: _____

Business Website: _____

Providers Names and Credentials: _____
(Add more on second page if needed)

_____

_____

Contact Information: Contact Name: _____
(Add attachment if needed)

Business #1 Address: _____

Business #1 Phone: _____ FAX #: _____

Business #2 Address: _____

Business #2 Phone: _____ FAX #: _____

Contact Email: _____

Please check off what you would like to participate in:

☐ Website Listing ☐ Directory ☐ Networking Events ☐ Continuing Ed Events ☐ Social Events

MEMBERSHIP REQUIREMENTS

2021 Membership Fees - Payable to: *Coastal Wellness Collective*

☐ Joining Jan 1 - Aug 31: $100 ☐ Joining September 1 - Dec 31: $50

I hereby attest that all providers have an active state license to practice locally, and active professional liability insurance. Should either change, I will notify CWC within 30 days of such change.

_____
Authorized Signature of Group Representative

Office Use Only

Date Received _____ Check Name _____

Processed by _____ Check # & Amount_____

Notes: _____

_____