

IndianaCareCircle (ICC)

(formerly North Central Indiana
Continuity of Care)

I.C.C. MEMBERSHIP APPLICATION

Agency/Affiliation: _____ Date: _____

Name: _____

Business Address: _____

Business Phone: _____ Ext. _____ Fax: _____

Job Position: _____

Email _____ URL _____

Please give a brief description of your business

Please explain areas of interest that will contribute to the mission and goals of
ICC _____

Corporate Membership

Name: _____ Position: _____ Email Address: _____

Other attendees

Applications submitted for review to the Membership Committee. You will be notified upon approval.

ICC (make check payable to ICC)
Attention: Membership Committee
P.O. Box 4984
Lafayette, IN 47903
email: raymond.degner@ssfhs.org

Membership Annual Fee:	
Individual	\$40.00
Corporate	\$50.00
Optional Annual Web-link fee \$25.00	

I have read the ICC mission statement and understand the goals as well as the purpose of ICC. I understand ICC is a supportive network in providing educational resources for both the group and the Lafayette community to enhance continuity of care.

Name(signature) _____ Date

Approved by Executive Committee on the ____ day of _____, 20__.