

SOUTHLAND HISPANIC LEADERSHIP COUNCIL

MEMBERSHIP APPLICATION 2008*					
APPLICANT INFORMATION					
Organization Name:					
Contact Name:			Phone No:		Fax No:
Mailing address:					
City:			State:		ZIP Code:
E-mail:					
YOUR ORGANIZATION INFORMATION					
Mission statement or purpose:					
AREAS OF INTEREST					
		Health		Education	
		Youth		Immigration	
Other:					
SPECIAL SKILLS OR QUALIFICATIONS					
Language:					
Other:					
VERIFICATIONS					
Signature of applicant:					Date:
Name of Application recipient:					Date:
Approved or Denied:					Date notified:

Membership will be reviewed and approved or denied by the Board of Directors. **Dues are \$25.00 for Agency and/or \$15.00 for Individual.**

Voting: Upon payment of Annual Dues each member or member agency shall be entitled to one vote on each matter submitted to a vote of the members, which must be cast in person. Organizational members may be represented by any number of delegates at any meeting, but each organization is only entitled to cast one vote on each matter submitted to a vote.

Please mail application to:
Southland Health Leadership Council
 21110 S. Western Avenue
 Olympia Fields, IL 60461