Health Care Coalition of Orange County - HCCOC

Member Agreement

We, the representing persons from _____

agree to participate in the Health Care Coalition of Orange County as a/an

Chose One _____facility.

Facility Representative

Name	Date	Phone
Signature	**E-mail**	

Facility Alternate

Name	Date	Phone
Signature	**E-mail**	

Facility Information

Address	City	24 hour Phone
24 Hour E-mail	**Fax**	

Member Agreement

Please list all facilities/sites that you are representing for your organization. Please note that the Health Care Coalition of Orange County highly advises that organizations have one (1) representative and one (1) alternate for every FIVE (5) sites.

Facility Information #2

Address	City	24 hour Phone
24 Hour E-mail	Fax	

Facility Information #3

Address	City	24 hour Phone
24 Hour E-mail	Fax	

Facility Information #4

Address	City	24 hour Phone
24 Hour E-mail	Fax	

Facility Information #5

Address	City	24 hour Phone
24 Hour E-mail	Fax	