



APPLICATION FOR PEHSC COUNCIL AFFILIATE MEMBERSHIP

Mission

The Pennsylvania Emergency Health Services Council (PEHSC) is a 501 (c)(3) non-profit organization. The core mission of the Pennsylvania Emergency Health Services Council is to serve as an independent advisory body to The Department of Health and all other appropriate agencies on matters pertaining to Emergency Medical Services. As an advocate for its diverse member organizations, PEHSC's ultimate purpose is to foster improvements in the quality and delivery of emergency health services throughout the Commonwealth.

Vision

Pennsylvania will be a national leader in developing a unified system of high quality emergency medical services and other health services. In partnership with other organizations statewide that are involved with emergency services, PEHSC's future role will include a heightened emphasis on advocacy and legislative liaison, outcomes research, system finances and development, public education, and resources to enhance organizational management.

Please return the completed application to:
Pennsylvania Emergency Health Services Council
600 Wilson Lane, Suite 101
Mechanicsburg, PA 17055
Fax: (717) 795-0741
pehsc@pehsc.org

Your Voice in EMS

APPLICATION FOR PEHSC COUNCIL AFFILIATE MEMBERSHIP

Name of Organization: _____

Organization Address: _____

Telephone: (_____) _____ Fax: (_____) _____

Organization Website: _____

Organization Email: _____

Primary Contact: _____

Primary Contact Address: _____

This address is my: Home Work

Primary Telephone: (_____) _____ Primary Fax: (_____) _____

Primary Email Address: _____

Secondary Contact: _____

Secondary Contact Address: _____

This address is my: Home Work

Secondary Telephone: (_____) _____ Secondary Fax: (_____) _____

Secondary Email Address: _____

Organization Type:

- | | |
|---|--|
| <input type="checkbox"/> Non-Profit BLS | <input type="checkbox"/> For Profit EMS |
| <input type="checkbox"/> Non-Profit ALS | <input type="checkbox"/> Hospital for Profit |
| <input type="checkbox"/> Hospital for Non-Profit | <input type="checkbox"/> Regional EMS Council |
| <input type="checkbox"/> Industrial Health Care | <input type="checkbox"/> Government (Describe _____) |
| <input type="checkbox"/> State Organization/Association | <input type="checkbox"/> Regional Organization/Association |
| <input type="checkbox"/> Training Site | <input type="checkbox"/> Other _____ |

Year of Incorporation: _____

Please record your mission statement. (Use a separate sheet if necessary):

Please describe your geographical representation. (Use a separate sheet if necessary – i.e. local, regional, statewide)

Two signatures are required to validate the application.

Primary Contact Signature: _____ **Date:** _____

CEO/President Signature: _____ **Date:** _____