NW HEALTHCARE COALITION MEMBERSHIP APPLICATION		
Agency Name:		
Agency Street Address:		
City:	State:	ZIP Code:
Agency Point of Contact (POC):		
POC Phone:	POC Email:	POC Fax:
Brief Description of Agency Services:		
LOCAL COALITION PARTNER AGENCIES		
Local Coalition Partner Agency Name:		
Local Coalition Partner Agency POC:		
POC Phone:	POC E-mail:	
Local Coalition Partner Agency Name:		
Local Coalition Partner Agency POC:		
POC Phone:	POC E-mail:	

EXPECTATIONS OF PARTICIPATION AND MEMBERSHIP

1. Read and abide by the Bylaws of the Northwest Healthcare Coalition (NW HCC).
2. Abide by the concepts found within the NW HCC Preparedness Plan and Response Plan.
3. Maintain a minimum of one (1) POC on the NW HCC email list.
4. Attend a minimum of two (2) coalition meetings annually.
5. Agency POC is expected to complete ICS 100, ICS 200, and ICS 700 training.
6. Actively participate in a county/local healthcare coalition of choice (if a county coalition is available in your area).

SIGNATURE

The undersigned Authorized Representative acknowledges the expectations of participation and membership described in this application.

Name:	
Title:	
Signature of Authorized Representative:	**Date:**

Return completed application by email to: smurphy@hcno.org