**MEMBERSHIP APPLICATION**



Name:

Business name:

Business address:

*(Do you work from home? Y/N)*

Work Phone:

Mobile Phone: Website:

E-mail: Facebook page:

Briefly describe your business/services you provide:

How did you hear about this group?

What do you know about us?

What do you feel you will contribute ?

Please list your relevant qualifications:

Are you with a registered body? Please name:

How long have you been in business?:

**References:** Please provide 2 references (preferably satisfied clients, otherwise business contacts/professionals who have done business with you). ***These references should be submitted with your application form.***

**Membership fees:**

The non-refundable annual membership fees are currently $100[[1]](#footnote-1) from January of the joining year, decreasing as the year progresses, but always renewable in January at $100.

January, February, March: $100

April $90

May $80

June $70

July $60

August $50

September $40

October $30

November, December $20

If accepted, I agree to pay the membership fees to HB Health Collaborative 03 1517 0059640 000.

Signed………………………………………………………………………………………. Date……………………………………………….

**If you are accepted, we will require your logo for inclusion on the HBHC website, together with a brief paragraph summarising your services. You will hear from a member of the team once your application has been considered.**

1. Membership fees may increase, but will not do so without members’ awareness [↑](#footnote-ref-1)