

## FAFC Membership Application

NAME OF CLINIC: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

LOCATION ADDRESS (if different): \_\_\_\_\_

WEBSITE: \_\_\_\_\_

EXECUTIVE DIRECTOR: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

CONTACT PERSON FOR FAFC: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

HAVE YOU COMPLETED THE FREE CLINIC SURVEY? Yes \_\_\_\_\_ No \_\_\_\_\_

To complete the survey visit: [www.surveymonkey.com/s/BRXRCTW](http://www.surveymonkey.com/s/BRXRCTW)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE

*Mission: To provide support, mentoring, networking opportunities and advocacy through a network that initiates collaboration and the sharing of best practices to improve access to health care for the uninsured in the State of Florida.*

***For Office Use Only***

FAFC Membership # \_\_\_\_\_

Date Completed the Survey \_\_\_\_\_

*In collaboration with the Health Council of South Florida, Inc.*

