



Healthy
CHARLOTTE ALLIANCE

Join us as we further our mission to improve the health and quality of life for all people of Mecklenburg County by funding health initiatives and providing education programs.

Membership Form

NAME (AS PREFER LISTED IN DIRECTORY): _____

HOME ADDRESS: _____

CITY, STATE ZIP: _____ BIRTHDAY (MONTH, YEAR): _____

PREFERRED PHONE: _____ PREFERRED EMAIL: _____

HOW DID YOU HEAR ABOUT THE ALLIANCE? _____

HEALTHY CHARLOTTE ALLIANCE MEMBERSHIP (JUNE 1, 2018 - MAY 31, 2019) - \$50

ANGEL DONATION (OPTIONAL)

Your generous investment supports programs and operations for Healthy Charlotte Alliance. (100% tax-deductible)

\$100 \$200 \$250 Other \$ _____

Please include how you would like your name listed for acknowledgement purposes.

 My gift is in memory of _____

My gift is honor of _____

Please notify the following of my gift in their name. (name and address)

Please make checks payable to [Healthy Charlotte Alliance](http://HealthyCharlotteAlliance.org) and mail with this form to
Healthy Charlotte Alliance | 5960 Fairview Road, Suite 400 | Charlotte, NC 28210

Or

Join online using PayPal or your credit card by visiting

HEALTHYCHARLOTTEALLIANCE.ORG