Ithaca Health Alliance Affiliate Membership Form

We/I wish to join the Ithaca Health Alliance as Affiliate Members, for the donation amount listed below. We/I understand that Affiliate Members may not access services limited to General Membership of the Ithaca Health Alliance. We/I have specified which IHA programs, if any, the membership donation is to be reserved for.

Last Name: ________________________ First Name: ____________________
Last Name: ________________________ First Name: ____________________
Street Address: ____
____
City: ____________________ State: __________ Zip Code: ____________

Phone Number: ____
Email Address: ____
Signed: ____
____

This donation is to be earmarked for the following IHA Program(s):

- ☐ Education Programs
- ☐ Free Clinic
- ☐ Grants and Loans (Ithaca Health Fund)
- ☐ Memberships donated to persons meeting charitable class criteria specified by IHA Board
- ☐ General donation, no program preference

Comments:
____
____
____
____

Would you like your name to be listed on the IHA donor list, which may be published on the organization's website or in other media?

☐ Yes ☐ No

Affiliate Membership information:	Amount of Donation	$
	Ithaca HOURS	
	Total enclosed:	$

Visa/MasterCard: ____________________ Expiration date: __________ Verification #: ______

Signed: ____

Please print and sign this form, include a check payable to "Ithaca Health Alliance", and any Ithaca HOURS.

Mail to: Ithaca Health Alliance, PO Box 362, Ithaca, NY 14851

http://www.ithacahealth.org/ office@ithacahealth.org (607) 330-1253