MEMBERSHIP APPLICATION FORM

PROPOSED MEMBERSHIP CATEGORY
Please check just ONE of the following boxes:

☐ Not-for-Profit Group  ☐ Trade Association
☐ Company  ☐ Law Firm/Consulting Firm
☐ Individual*  ☐ Other

*Please note that current employees of the FDA are not eligible for membership of the Alliance.

NAME AND CONTACT INFORMATION OF PROPOSED MEMBER
Name of proposed member (if a company or other organization):
__________________________________________________________________________

Name of individual representing company:
__________________________________________________________________________

Full contact information:

[Street] ____________________________________________
[Bldg/Suite #] _______________________________________
[City] _______________ [State] ___________ [ZIP] ___________
[Tel] ___________   [Fax] ___________   [E#mail] __________________________

Name of proposed member (if an individual):
__________________________________________________________________________

Full contact information:

[Employer – if relevant] _______________________________________________
[Street] ____________________________________________
[Bldg/Suite #] _______________________________________
[City] _______________ [State] ___________ [ZIP] ___________
[Tel] ___________   [Fax] ___________   [E#mail] __________________________

SIGNATURE: ________________________________  DATE: ____________________________

NAME: ______________________________________
TITLE: ______________________________________

Please complete and MAIL this form to the Alliance at the address given above. Alternatively, a copy of this form can be FAXED to the Alliance at 301-576-5416 or E-MAILED to info@StrengthenFDA.org.