

## Arkansas Healthy Aging Coalition Membership Form

<b>Member Information *</b>		
<b>Name:</b>		
<b>Title:</b>		
<b>Agency/ Organization/ Company Name:</b>		
<b>Contact Information</b>		
<b>Telephone:</b>	<b>Fax:</b>	
<b>Street Address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>
<b>Mailing Address (if different from street address):</b>		
<b>E-mail:</b>		

\*If there are multiple members from the same agency/organization/company, then each member must complete the table. The questions below only need to be answered by one person.

**What is your organization's interest in healthy aging in Arkansas?** (E.g. Vision, mission, goals, objectives, agenda, interest, etc.)

**Briefly describe your organization.**

**What can you and/or your organization bring to the AR Healthy Aging Coalition?**

**Where do you see yourself and/or your organization fitting into the AR Healthy Aging Coalition?**  
(E.g. specific workgroup, level of involvement, skills/ expertise, specific interest area, etc.)

**What would you and/or your organization like to get out of the coalition?**

Note: If there is a conflict of interest, the person may not make any attempt to influence a decision pertaining to the organization.  
 Mail or fax completed forms to: AR Healthy Aging Coalition, Arkansas Department of Health,  
 4815 W. Markham St., Slot 41,  
 Little Rock, AR 72205  
 Fax: (501) 661-2055