



US COPD Coalition

Membership Application



Date:

1. Please provide us with the following information about your organization:

a. Name of organization:

b. Website URL:

c. Address 1:

d. Address 2:

e. City:

State:

Zip Code:

2. Primary contact person:

a. First and Last Name:

b. Title:

c. Email address:

d. Phone number:

3. In what state is your organization incorporated?

4. What best describes the classification of your organization? (Please use dropdown menu)

5. What best describes the legal status of your organization? (Please use dropdown menu)

6. Does your organization have a mission statement? If yes, please provide it. **Yes** **No**

7. Please tell us about your organization's programs. You may also use this space to provide any additional information about your organization.

8. I am authorized to complete this application on behalf of my organization. **Yes** **No**

Please download completed application and email to

ksiegel@uscopdcoalition.org