California Consortium of Addiction Programs and Professionals

PROGRAM MEMBERSHIP APPLICATION

Non-Voting Member	Voting Member
____ Supportive Business $200	_____ Program Membership $500

Program Name: ____

Type of Program ___________________________Population Served__________________________

No. of Administrative Staff ____ No. of Program Staff ____ No. of Other Staff ____ No. of Beds _____

Contact Person: ____________________________________Work Phone: (_____) _______________

Home/Cell Phone: (___) _____________________ E-mail:_______________________________________

Voting Representative: ____

Program Website: ____

Program Address: ____

City: ____State: ____________ Zip Code: ____________

METHOD OF PAYMENT:

1. ____Check ____Money Order

Mail with fee to: **CCAPP,** P. O. Box 214127**,** Sacramento, CA 95821

2. _____ Visa _____ MasterCard _____ American Express _____ Discover

Mail to address above or fax to: **CCAPP,** (916) 338-9468

Card Number ____

Expiration Date _____________________ 3 or 4 digit Security Code on Back_______________

Name as it appears on Card ____

Signature ____

Billing address for card ____

PLEASE ALLOW 4 WEEKS FOR DELIVERY

RETURNED CHECKS/DECLINED CREDIT CARDS WILL RESULT IN A $30.00 ADDITIONAL FEE