Grief Support Network

Membership Application

____

Name (Individual Member or Organization)

____

Mailing Address

(_____)________________________

Telephone Number

(_____)________________

Fax number

____

Email Address

Preferred method of contact:

____

Please briefly describe your specialty areas or organization:

____

____

Annual membership fee information:

A. $30 for individuals
B. $60 for companies with 2 or less employees attending the monthly meetings
C. $75 for agencies in which more than 2 employees attend the monthly meetings

Please indicate what membership option you are selecting: ______________

Make checks payable to Grief Support Network

Mail this form and payment to:
The Grief Support Network
P.O. Box 2114
Shawnee Mission, KS 66202