

Tennessee Initiative for Perinatal Quality Care

INDIVIDUAL MEMBERSHIP APPLICATION

Name _____

Title _____ Degrees _____

Primary Organizational Affiliation (Hospital, Business, non-profit) _____

Address _____

City _____ State _____ Zip _____

Email: _____

Phone(s): _____ (w) _____ (c) _____

Fax: _____

Area of Expertise willing to share with TIPQC: _____

Privacy Statement: TIPQC will not sell, share, or distribute your address or personal information to anyone.

This is a voluntary, collaborative association.

Signature _____ ***Date of application*** _____

Please complete this information and return to:

TIPQC Office

Attn: Brenda Barker

Fax: (615) 343-6182

If healthcare provider where do you practice? _____
