Healthcare Coalition: **Participation Response**

Organization ____

Address ____

City ____________________ State __________ Zip ______________ County ________________

Contact Person ______________________________________ Phone ________________

Email ____

Organization Type (please select one): ____Hospital ____Nursing Home ____EMA ____EMS ____Other________________

Please sign and return to the address below:
On behalf of my organization I would like to attend healthcare coalition meetings and provide input as long as my participation does not hinder, interfere or become burdensome to my organization's ability to conduct operations day to day or during an event.

Signature ______________________________________ Date ________________

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OR

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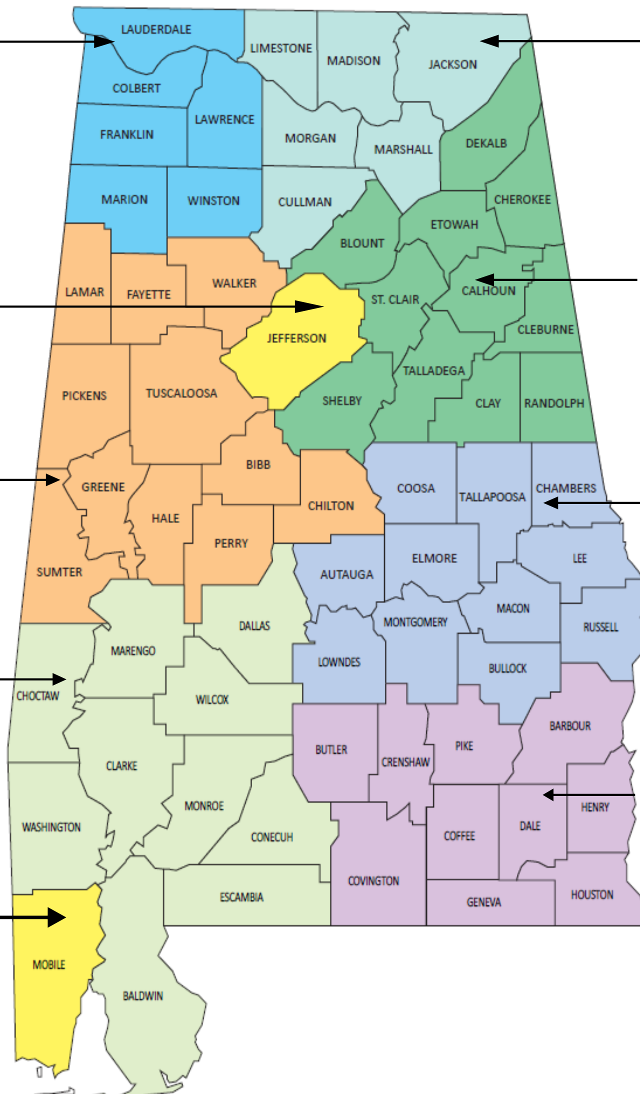

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