National Association of Free & Charitable Clinics
Membership Application Form

Organization Name: ____

Physical Address:______________________City:__________State:_____ZIP: ________

Mailing Address:______________________City:__________State:_____ZIP: ________

General Phone (for website):________________Admin Phone (for NAFC staff): ________________

Primary Contact Name:________________Primary Contact Email: ________________

Additional Contact:________________Additional Contact Email: ________________

Federal EIN:________________Cash Operating Expenses: ________________

Website: ____

Does your organization charge any fees to patients? ☐ No ☐ Yes – If yes, how much?____________

Do you bill any of the following insurance programs? ☐ Medicaid ☐ Medicare ☐ SCHIP ☐ Other ☐ None

NAFC Dues Schedule:

Current Cash Operating Budget	Dues
Student-Run Clinic	**$240**
$0-250,000	**$240**
$250,001-500,000	**$420**
$500,001-750,000	**$900**
$750,001-1M	**$1,200**
$1,000,001-3M	**$1,800**
$3,000,001+	**$2,400**

NAFC Dues Amount (see table on right): $________________

**SIGNATURE:*________________________Date: __________

By my signature, I attest that I verified compliance with NAFC membership eligibility criteria. I understand that the NAFC will negotiate and bind on behalf of its members, discounted prices with partners, vendors, companies and others, and that these partners may contact my organization to discuss member benefits. I understand that a requirement of NAFC membership is to provide annual data reports and/or surveys as requested. I understand that the NAFC may utilize submitted data to secure funding and in-kind donations for its membership, as well as for advocacy and storytelling. I understand that the NAFC provide best practice resources, listserves and guidance to Member Organizations, however, it is each members responsibility to confirm with legal counsel, state and local laws. The National Association of Free and Charitable Clinics does not and shall not discriminate on the basis of race, color, religion (creed), gender, gender expression, age, national origin (ancestry), disability, marital status, sexual orientation, or military status, in any of its activities or operations.

☐ I will be mailing in my membership dues payment by check.
☐ I would like to pay for my membership by credit card, please use the following information for payment:

Name as it appears on card:______________________________☐ Visa ☐ MasterCard ☐ Amex

Billing Address for card: ____

City:______________________State:__________Zip Code: ____________

Card #:______________________________Exp. Date: ______________

Signature:______________________________Security Code: ____________

Please email the following scanned documents to melanie@nafcclinics.org : IRS Form 990, IRS 501c3Determination Letter, and Board of Directors List.

Please make your check payable to the NAFC and mail to:
National Association of Free & Charitable Clinics
1800 Diagonal Road, Suite 600, Alexandria, VA 22314
Phone: 703-647-7427 – melanie@nafcclinics.org