MONTANA CANCER CONTROL COALITION

Working together...

Member Information Form

Name: _____
Title *First* *Last* *Credentials*

Organization: _____

Address (mail):_____
City *State* *Zip*

Address (delivery): _____
City *State* *Zip*

Phone 1: _____ Phone 2: _____

Email: _____ Fax: _____

Check the Montana Cancer Control Coalition (MTCCC) implementation group(s) you wish to join:

- ☐ Prevention Team
- ☐ Early Detection Team
- ☐ Treatment & Research Team
- ☐ Quality of Life & Survivorship Team
- ☐ Communication Committee
- ☐ Resources and Membership Committee
- ☐ Assessment and Development Committee
- ☐ Provider Advisory Group

Are you 18 years of age or older? ☐ Yes ☐ No *If no, name of adult sponsor* _____

*If you are the **lead** representative of your organization's commitment to the MTCCC with authority to commit or make resource requests and officially speak and act on behalf of the organization, please sign below.*

Lead Representative signature: _____

Please indicate resources and assets that you or your organization can dedicate to implementing the Montana CCC Plan. (For example: contribution of time, educational materials, training expertise, conference calling, conference room rental, honorariums, media access, advocacy expertise, etc.)

_____

_____

Please send form to Outreach Coordinator; MCCCP
P.O. Box 202951 Helena, MT 59620-2951
Fax: (406)444-7465 *cancerinfo@mt.gov*