Wyoming
Public Health Association
WYOMING'S PUBLIC HEALTH RESOURCE

Member Application

Level:	**Individual**	**$30/yr.**	**_____**
	Student	**$15/yr.**	**_____**
	Agency	**$100/yr.**	**_____**
	Sponsoring/Exhibiting	**$60/yr.**	**_____**

First Name: _____
Last Name: _____
Organization/School: _____
E-mail: _____
Phone: _____
FAX: _____
Degree: _____
Job Title: _____
Website: _____

Preferred Mailing Address: _____
_____
_____

How did you hear about us? (circle one) **Internet** **Referral**
Are you a member of APHA? **Yes** **No**

Please make check payable to: Wyoming Public Health Association

Mail to: **WPHA**
PO Box 21457
Cheyenne, WY 82003