



- Please list me/my organization as a member of **California Partnership for Access to Treatment (CPAT)**. I am/our organization is committed to increasing access to prescription medicines to ensure a healthy and productive California.

Please select a membership category:

- Individual
 Organization/Company
 Public Official

Please complete the following:

Name

Title

Organization/Company (if joining as an Organization/Company Member)

Address

City State Zip

Phone Fax

Email

Signature Date

- Please email updates to me on upcoming programs.**
- Please link my organization's name on the CPAT website with our organization's website.**
Website address:_____
- Please list my organization's events on the CPAT website.**
 Events are listed on our website at: www._____
 Call me for a listing of future events to post.

Thank you for joining California Partnership for Access to Treatment

Please return this form to:

California Partnership for Access to Treatment
925 L Street, Suite 1200
Sacramento, CA 95814
Fax Number: (916) 658-0155