



# New Membership Application Form

2002-2003

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Organization/Company: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Organization/Company Web Site Address: \_\_\_\_\_

Type of AIRA Membership Requested (check one):

- Individual Member @ \$75
- Organization Member @ \$195
- Affiliate Organization Member @ \$195
- Sustaining Member @ \$1000
- Individual Retired Charter Member/Free

Enclosed is a check and/or money order in the amount of \$\_\_\_\_\_

Check or money order should be made payable to **AIRA/MHRA Membership** and returned to:

**Cindy Sutliff, Executive Director**  
**AIRA @**  
**Medical and Health Research Association of New York City, Inc.**  
**NYC Department of Health**  
**c/o Citywide Immunization Registry**  
**125 Worth Street, Box 64R**  
**New York, NY 10013**

I am interested in participating on an AIRA Committee. Check one.

\_\_\_ Education Committee

\_\_\_ Technical Committee

\_\_\_ Urban/City Registries Committee