



COALITION MEMBERSHIP FORM

Purpose: By completing and returning this form, you indicate an interest in becoming or staying involved in the Connecticut Health Improvement Coalition. As a Coalition member, you become part of a system of partners working together to achieve the vision and goals of Healthy Connecticut 2020 and improve the health of Connecticut residents. You and/or your organization may be identified on the website as a member of the Connecticut Health Improvement Coalition, receive information and updates, and have opportunities to participate in Action Teams or other implementation activities of the State Health Improvement Plan.

Instructions: Please complete this form and click on the "submit form" button in the upper right corner. You may also access this form online at www.ct.gov/dph/SHIPCoalition. If you would like to keep a copy for your records, you should first print your completed form prior to clicking on the "submit form" button.

Contact Information:

Contact Name: _____ Credentials (optional): _____

Position: Title: _____

Name of Agency or Organization: _____ Name of Program or Service: _____

Street Address: _____ City/Town: _____ State: _____ Zip: _____

Telephone No. (____) ____ - ____ Extension: _____ Fax No. (____) ____ - ____

E-mail: _____

Website: _____

1. I will be participating as:

The designated representative for my agency
 An individual

2. My agency/organization will provide a link on our webpage to the Connecticut Health Improvement Coalition webpage (www.ct.gov/dph/SHIPCoalition): Yes No

3. The scope of my agency's /organization's work is (check one): Statewide Regional Local Tribal

Please indicate which sector best describes your agency/organization (select one)

<input type="checkbox"/> Agriculture/food	<input type="checkbox"/> Elected Official (state or local)	<input type="checkbox"/> Laboratory
<input type="checkbox"/> American Indian Tribe	<input type="checkbox"/> Faith Community	<input type="checkbox"/> Legislative Commission
<input type="checkbox"/> Business and Industry (health insurer, other business, professional assoc.)	<input type="checkbox"/> Health Care Provider (medical, dental, behavioral)	<input type="checkbox"/> Parks & Recreation
<input type="checkbox"/> State agency or office	<input type="checkbox"/> Local Health Department	<input type="checkbox"/> Philanthropy
<input type="checkbox"/> Community Service Providers (Elder, Family/Youth, special populations)	<input type="checkbox"/> Housing/Building Safety	<input type="checkbox"/> Health Professional Associations
<input type="checkbox"/> Education (Higher Ed/Technical College)	<input type="checkbox"/> Non-profit Organizations and Coalitions (e.g., Cancer, heart, HIV/Aids, Injury etc.)	<input type="checkbox"/> Transportation
<input type="checkbox"/> Education (Head Start, Pre-K, K-12)	<input type="checkbox"/> Justice/Law Enforcement	<input type="checkbox"/> Other (please specify): _____