

**FNBHA Membership Application**  
**(\* = required field)**

**Type of Membership\***

- Individual/Consumer/Family - \$5.00
- Provider - \$50.00
- Organizational - \$250.00
- Tribal - \$250.00

**Name\*** \_\_\_\_\_

**Address\*** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Home Phone\*** \_\_\_\_\_

**Work Phone** \_\_\_\_\_

**E-Mail Address\*** \_\_\_\_\_

**Enrolled Tribal membership & descendent of enrolled tribal member (list Tribe(s))\***

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Personal/Professional interest in joining?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please mail the appropriate amount by check to:**

**Jill Shepard Erickson**

**PO Box 55127**

**Portland, OR 97238**