Provider Collaboration Membership Application

Date: _____

Member Name: _____ **List of Credentials:** _____

Phone Number: _____

Email: _____

Business Name: _____ **Business Address:** _____

Business Phone: _____ **Business Email:** _____

Hours of Operation: _____ **Website:** _____

Social media: _____

Services Offered:

_____

_____

Partner, Board, or other Affiliations: _____

Membership Type

- □ Monthly ($25.00)
- □ Annually ($300.00)

Payment and Billing

Payment Method:

- □ Debit/Credit
- □ PayPal
- □ ACH

- □ **I authorize New Life Solution, LLC to charge my account per the selected plan.**

Member Name: _____

Signature: _____ **Date:** _____