**SDAHMPR**

**Membership Application / Renewal**

**South Dakota Association of Healthcare Marketing & Public Relations**

Name (please print):

Title:       Years in this position:

Hospital-Facility-Organization:

Address:

City:       State:       ZIP:

Phone Number:       Fax Number:

E-mail address:

Signed: Date:

Dues: $35.00

**Make Check Payable to SDAHMPR.**

Send application and check to:

SDAHMPR

c/o SDAHO

3708 W Brooks Place

Sioux Falls, SD 57106

Phone: 605/361-2281

FAX: 605/361-5175