By signing this document, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Name of Facility/Agency), will participate in the Central Minnesota Healthcare Preparedness Coalition (CMHPC) in the following ways (check all that apply):

**CMHPC Bylaws**

[ ]  I have reviewed the CMHPC bylaws at: <http://www.cwchealthcarecoalitions.org/cmhpc/central-mn-hpc-regional-all-hazards-plan/> and by checking this box, I agree to be a member of the coalition as described in the CMHPC bylaws.

**CMHPC Memorandum of Understanding (MOU)**

[ ]  I have reviewed the CMHPC MOU at: <http://www.cwchealthcarecoalitions.org/cmhpc/central-mn-hpc-regional-all-hazards-plan/> and by checking this box, I agree to collaborate and assist other healthcare facilities/agencies as resources allow during times of disaster / crisis, as described in the CMHPC MOU.

[ ]  I have completed a W-9 for my healthcare facility/agency and understand this document needs to be completed prior to receiving reimbursement. The W-9 form can be found at: <http://www.cwchealthcarecoalitions.org/cmhpc/cmhpc-documents-and-forms/>

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

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

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_