

# RiverView Health



## Association Membership Application Form

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip Code \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip Code \_\_\_\_\_

**Note: Only individual memberships are sold, i.e. a couple or a business must purchase a membership for each individual separately.**

**Membership cost is \$3.00 for 3 years.**

**Please submit application and payment to:**

**RiverView Healthcare Association  
323 South Minnesota Street  
Crookston, MN 56716**

**Attn: Sharon Lanctot, Administration**

**TOTAL AMOUNT ENCLOSED \$ \_\_\_\_\_**