



# SOUTH CAROLINA HIV TASK FORCE

## MEMBERSHIP APPLICATION

Category of Membership (Select One):  New  Renewal

Name: \_\_\_\_\_  
*FIRST NAME MI LAST NAME*

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
*MM DD YYYY*

Permanent/Mailing Address:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Official use only:**  
Membership #: \_\_\_\_\_  
Membership fee: \$ \_\_\_\_\_  
Method of Payment: \_\_\_\_\_  
Receipt #: \_\_\_\_\_  
By: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Mobile Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Indicate preferred method of contact:

- Email  Mobile Phone  
 Home Phone  Postal Mail

Please indicate how you learned about SCHTF: \_\_\_\_\_

If you would like to be actively involved and have time to devote would you like to serve on a committee? (Please select one):

Yes  No

### **“United Advocacy for quality HIV prevention, treatment, care & support services”**

The information contained within this document is privileged and private between South Carolina HIV Task Force (to be identified further as SCHTF), and the Applicant mentioned above. Information contained within this document will not be given to any third party in any way or by any means whatsoever without the express written permission of the applicant, unless circumstances arise that it is a legal requirement to do so, and under these circumstances the applicant or the applicant's parent or guardian if under the age of 18 yrs and SCHTF will be notified accordingly.

Indicate your area of interest within SCHTF. (Please check all that apply):

- |  |  |
|--|--|
| <input type="checkbox"/> Direct Advocacy with Legislators<br>(Visits, calls, emails) | <input type="checkbox"/> Event Coordination and planning |
| <input type="checkbox"/> Advocacy with media   | <input type="checkbox"/> Public speaking                 |
| <input type="checkbox"/> Resource Development  | <input type="checkbox"/> Committee leadership            |
| <input type="checkbox"/> Other   |  |

Please select your shirt size:    small    medium    large    extra-large    2xl    3xl

To become a member, please **fill out this application completely** and submit it with your **membership fee** to any **SC HIV Task Force** Executive Committee Member or mail to:

South Carolina HIV Task Force  
c/o: Membership  
P.O. Box 624  
Columbia, SC 29202

**Responsibility of Individual Members**

- To be present at each SCHTF meeting or notify the meeting coordinator of your absence in advance of meeting
- To participate in advocacy activities of the SCHTF
- To agree to avoid conflicts of interest or potential conflicts of interest in the work of the SCHTF.
- To follow through on all commitments made to the SCHTF.

I would like to become a member of SC HIV Task Force (SCHTF) and have filled out this application completely and accurately. I am submitting dues of \$ \_\_\_\_\_ along with my application and agree that this information will held on my record for as long as I am a member.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



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