



Date: _____

2009 Member Information

(Please type or print clearly)

Agency Name: _____

Address: _____

City/Zip _____

Phone(s): _____

Cell Phone: _____

FAX: _____

Website: _____

Emails: _____

Name of CRA Representative(s): _____

Job Title(s): _____

Total Number of Respite Families (For all types of respite) Served by-----

Total Number of Respite Providers (For all types of respite) Employed by Agency

Total Combined-----

- Returning Member (enclosed is my \$ _____ fee for 2009)
 New Member (Agency not a previous member of CRA)

Membership is for the calendar year and entitles the lead representative to represent their agency during CRA discussions and vote at association meetings.

Please return this form and check to:

California Respite Association
Dianne Rose, Treasurer
Tri-County Respite Services
P.O. Box 1296
Yuba City, CA 95992

New Members: Please fax this form to Dianne Rose at 530 755-3773 by 1/30/09

c/o Bay Respite Care 3272 Sonoma Blvd. #4 Vallejo, CA 94590 T: 707.644.4491 F: 707.644.1318