



EMERGENCY NETWORK OF LOS ANGELES MEMBERSHIP APPLICATION 2011-2012

Any nonprofit, community, or faith-based organization that plans to provide disaster/emergency-related services in Los Angeles County is eligible to be a **voting member** of ENLA. Any such government agency or private sector business is eligible to be a **non-voting member** of ENLA. We look forward to receiving your application.

Complete this Membership Application (for nonprofits) and submit it with the following:

- A copy of your IRS 501(c)3 tax-exempt letter;
- A copy of your organization's mission statement and brochure (if available);
- A Disaster Mission Statement if available (we can provide the template to you later if needed); and
- A check for our annual membership dues – made payable to Emergency Network Los Angeles

Dues are based on your organization's annual budget. Dues for entities with annual budgets greater than \$250,000 are \$100/year, and dues for entities with annual budgets less than \$250,000 are \$50/year. Please list the area(s) you serve, such as your city, neighborhood, all of LA County, national, international, etc.

Annual budget: \$ _____ Amount enclosed: \$ _____ Area served: _____

Legal Name of organization: _____

Web Address: _____ Fiscal year (months): _____ to _____

Organization/Main Address: _____

Main Phone #: _____ Main Fax #: _____

Name of Executive Director/Senior Clergy: _____

Primary Liaison to ENLA: _____ Liaison E-mail Address: _____

Contact/Liaison Address (if different than main): _____

Liaison Phone #: _____ Liaison Fax #: _____

After-Hours Contact: _____ After-Hours Phone: _____

What kind of service(s) do you provide? (Check all that apply)		Which ENLA committee(s) would you like to work with? (Check all that apply)	
<input type="checkbox"/> Feeding <input type="checkbox"/> Transportation <input type="checkbox"/> Shelter & Homeless <input type="checkbox"/> Volunteers <input type="checkbox"/> Medical Health <input type="checkbox"/> Mental Health <input type="checkbox"/> Elderly/Disabled Services	<input type="checkbox"/> Language/Translation <input type="checkbox"/> Spiritual/Religious <input type="checkbox"/> Legal Aid/Counseling <input type="checkbox"/> Animal Services <input type="checkbox"/> Information Services <input type="checkbox"/> Communications/Technology <input type="checkbox"/> Other _____	<input type="checkbox"/> Membership <input type="checkbox"/> Development & Marketing <input type="checkbox"/> Mass Care <input type="checkbox"/> Long Term Recovery <input type="checkbox"/> Communications	<input type="checkbox"/> Case Management <input type="checkbox"/> Donations Management <input type="checkbox"/> Volunteer Management <input type="checkbox"/> Emotional & Spiritual Care

Signature: _____ Title: _____ Date: _____

(Please Note: Application must be signed by Executive Director/Senior Clergy or Board Chair/President)

Cooperation, Communication, Coordination, Collaboration