



**Access to Benefits Coalition  
Local Organization Participation Form**

\_\_\_\_\_ Yes, my organization wishes to participate in a local Access to Benefits Coalition effort

\_\_\_\_\_ We may wish to participate but need further information

**Organization Name:** \_\_\_\_\_

**Respondent or Primary Contact (if other than respondent):**

**Name:** \_\_\_\_\_

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

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

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**E-mail Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_ **Fax Number:** \_\_\_\_\_

**Please indicate the areas of expertise that your organization may be willing to bring to the local Coalition:**

**1. Public Relations**      **Name** \_\_\_\_\_ **E-mail Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**2. Marketing**              **Name** \_\_\_\_\_ **E-mail Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**3. Significant Community**      **Name** \_\_\_\_\_

**Linkages with**

**Other Organizations**      **E-mail Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**4. Enrollment Expertise**      **Name** \_\_\_\_\_ **E-mail Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

*Please complete and return your form by e-mail to [info@abcrx.org](mailto:info@abcrx.org) or by fax to 202-479-0735.  
Attention: Barbara Shaheed.*