Date____/____/_____

Association of Black Cardiologists, Inc.

Membership for Non-Healthcare Providers is Complimentary

COMMUNITY HEALTH ADVOCATE

Completing the Circle of Cardiovascular Care

MEMBERSHIP APPLICATION

First Name_____ **M.I.**____ **Last Name**_____ **Date of Birth**_____/_____/_____
Address_____**City**_____ **State**_____ **Zip** _____
Phone _____ **Fax** _____ **Email** _____
Employer_____**Occupation**_____
Education □ High School □ AA □ BA □ BS □ MA □ MS □ MBA □ MPH □ PhD □ Other_____
Race/Ethnic Background (*strictly voluntary*) □ African American □ Caucasian □ Native American □ Hispanic □ Asian □ Other_____
Gender □ Male □ Female

ROLES OF THE COMMUNITY HEALTH ADVOCATE

A Community Health Advocate (**CHA**) through kindness, compassion, education, and leadership, works to remove barriers to good health which ultimately will make accessible the overall improved health of their community. A **CHA** relies on strength drawn from his or her community roots. While combining a volunteer's heart with dedication, sincerity, and concern, a **CHA** is ***more effective*** at motivating fellow community members to improve their health, ***than*** frightening statistics or generalized and impersonal pamphlets.

A Community Health Advocate functions in three (3) main capacities:

ADVOCATE: **Support and promote** cardiovascular care and education to legislative representatives, public and private stakeholders
INFORM: **Educate** community members on the risks of cardiovascular disease, as well as provide resources to promote the prevention and treatments
MOTIVATE: **Mobilize** communities at-large to actively begin living healthier lifestyles

YOU CAN HELP!

Would you like to volunteer? □ YES □ NO If yes, in which capacity? *(please check all that apply)*
□ Event Organizer □ Fundraiser □ Health Screenings □ Community Relations □ Spokesperson □ Administrative Support
□ Other_____

Are you interested in participating in training opportunities for Community Health Advocates? □ YES □ NO

Would you like to establish a HEALTH MINISTRY in your Community? □ YES □ NO

How Did You Learn About Us? *(please check all that apply)*
□ ABC Sponsored Educational Program
□ Health Fair/Health Screening
ABC □ Website □ Email □ Telephone
□ Other *(please list name/event location below)*
Thank You For Your Interest In ABC

Donations Accepted
TAX-DEDUCTIBLE CONTRIBUTION TO ABC
AMOUNT $_____ □ ANNUALLY □ QUARTERLY □ MONTHLY □ ONE TIME GIFT *Checks Payable To:* Association of Black Cardiologists, Inc.
CREDIT/DEBIT CARD #
Expiration Date / /
□ **V**isa □ **M**aster**C**ard □ **A**merican **E**xpress
NAME ON CARD **(Print)**
SIGNATURE

ASSOCIATION OF BLACK CARDIOLOGISTS, INC.
5355 Hunter Road, Atlanta, GA 30349 ● Phone: 404.201.6600 ● Toll Free: 800.753.9222 ● Fax: 404.201.6601 ● Web: www.abcardio.org