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**National Partnership for**

**Pediatric to Adult Care Transition**

**Member Agreement**

[ORGANIZATION NAME] is committed to being a member of the National Partnership for Pediatric to Adult Care Transition (NPPACT) that has been formed to advocate for federal programs, investments, and policies, which will help ensure smoother care transitions for people with congenital and pediatric on-set, chronic, and/or disabling conditions that were initially diagnosed, treated, and managed in childhood.

In specific, NPPACT will focus on:

* Adequate funding for medical transition
* Barriers to workforce supply, distribution, roles, professional medical education and training
* Sufficient payment and financial support for healthcare systems, physicians, and clinicians
* Recommend models of care

We are committed to the goals, objectives and strategies that have been or will be established and agree that our organization will not work to undermine NPPACT’s goals or objectives. We agree to dedicate time for meetings, calls, planning, and engaging in NPPACT activities. As a member of the NPPACT, our organization agrees to:

* Appoint a person who will represent our organization
* Attend NPPACT meetings
* Share relevant information with the NPPACT
* Share information with our supporters, members, and employees
* Participate in NPPACT activities
* Follow NPPACT policies adopted for participation in the NPPACT

**DUES**

The dues structure for NPPACT membership in 2023 are listed below. *In order to increase our strength as a coalition, we invite allied and professional groups to join NPPACT for $500.*

|  |  |
| --- | --- |
| Organization Revenue  under $5 million | Organization Revenue  over $5 million |
| $2,500 | $5,000 |

In addition, [insert organizational name] agrees to pay dues in the amount of $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**METHOD OF PAYMENT**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Send Invoice |  | Credit |

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|  | | | |
| Card # | | | |
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| CVV | Expiration | | |
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| Billing Address | | Address 2 | |
|  | | | |
|  | |  |  |
| City | | State | Zip |
|  | |  |  |
|  |  | | |
| Card Holder’s Name | Signature | | |

**ORGANIZATION INFORMATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | | | | |
| Organization Name | | | | |
|  | | |  | |
|  | | |  | |
| Street Address | | | Address 2 | |
|  | | | | |
|  | |  | |  |
| City | | State | | Zip Code |
|  |  | | | |
|  |  | | | |
| Organization Email | Organization Phone | | | |

**ORGANIZATIONAL REPRESENTATIVE TO NPPACT**

|  |  |
| --- | --- |
|  |  |
| First Name | Last Name |
|  |  |
|  |  |
| Title | |
|  | |
|  |  |
| Email | Phone |

**ORGANIZATIONAL AUTHORIZING OFFICIAL**

By signing onto this NPPACT agreement, [insert organization name] agrees to allow its name to be used in public statements as a member of the NPPACT.

|  |  |  |
| --- | --- | --- |
|  |  | |
| First Name | Last Name | |
|  | | |
|  | | |
| Title | | |
|  | | |
|  | |  |
| Signature | | Date |
|  | | |
|  |  | |
| Email | Phone | |

|  |  |  |
| --- | --- | --- |
| **Mail This Form & Payment to:**  Spina Bifida Association  1600 Wilson Rd. Suite 800  Arlington, VA 22209  NPPACT | **or** | **Email This Form to:**  Sara Struwe  President & CEO  sstruwe@sbaa.org |