CACFP NATIONAL PROFESSIONAL ASSOCIATION

Membership Form

State Name:	Agency Name:

Mailing Address:

City:	Zip:

Primary Contact:	Phone:	Email:

State Agency Membership Type:
(2-year membership)

☐ Institutional $400.00
(includes unlimited # of members, please designate 10 with voting rights)

☐ Individual $80.00

Name:		**Committee Interest(s):** ☐ Member Services ☐ Legislative ☐ Financial
Phone:		☐ Conference Planning ☐ Nominating
Email:		Voting Rights Y / N

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Please fill out form completely, with a check or money order payable to:
CACFP National Professional Association
FEIN: 45-0440145

Send form and check/money order to:
NYS DOH DON Child & Adult Care Food Program
ATTN: Sheri Alberti
150 Broadway, Suite 650
Albany, NY 12204

Additional forms are available on the website: www.cacfpnpa.org