Trillium HEALTH RESOURCES

Transforming Lives. Building Community Well-Being.

Provider Council Membership Application

Please save this form to a local drive on your computer prior to completing electronically.

APPLICANT'S INFORMATION		
Applicant's Name:		
Position Title:		
License Type(s):		
Certification(s):		
Provider/Agency Name:		
Address:		
County:		
Work Phone #:		Cell #:
Email Address:		

COUNTIES SERVED: (Check all that Apply)

☐ Anson	☐ Currituck	☐ Hyde	☐ Onslow	☐ Scotland
☐ Beaufort	☐ Dare	☐ Jones	☐ Pamlico	☐ Tyrrell
☐ Bertie	☐ Duplin	☐ Lee	☐ Pasquotank	☐ Warren
☐ Bladen	☐ Edgecombe	☐ Lenoir	☐ Pender	☐ Washington
☐ Brunswick	☐ Gates	☐ Martin	☐ Perquimans	☐ Wayne
☐ Camden	☐ Greene	☐ Montgomery	☐ Pitt	☐ Wilson
☐ Carteret	☐ Guilford	☐ Moore	☐ Randolph	
☐ Chowan	☐ Halifax	☐ Nash	☐ Richmond	
☐ Columbus	☐ Hertford	☐ New Hanover	☐ Robeson	
☐ Craven	☐ Hoke	☐ Northampton	☐ Sampson	

☐ Other (please specify): _____

PRIORITY POPULATIONS: (Check all that Apply)

☐ Hospital ☐ I/DD ☐ LIP ☐ Medical/ Primary Care ☐ MH

☐ SU ☐ **Other (please specify):** _____

Signature: _____ Date: _____

Click "Submit" when the form is completed: Submit