



Please indicate your purpose in completing this form by selecting from the options below and mailing to
Heartbeat International, 8405 Pulsar Place, Columbus, Ohio 43240.

One-year affiliation options:

- ☐ **Affiliate - \$250.00** Select this rate if you are not affiliated with another National Affiliation Organization and have been in existence for more than a year. (Go to www.HeartbeatServices.org for a complete list of benefits.)
- ☐ **Affiliate (Discounted) - \$200.00** This rate is for centers who are also affiliated with one or more of the following National Affiliation Organizations:
- ☐ Care Net ☐ NIFLA ☐ ICU Mobile (Image Clear Ultrasound) ☐ Life Matters Worldwide ☐ Christian Life Resources ☐ Christian Adoption Alliance ☐ National Life Center ☐ National Christian Adoption Fellowship ☐ Save the Storks
- ☐ **Affiliate (Complimentary) - \$0.00** This rate is for start-up centers in their first year. All others will be subject to cancellation.

Contact information:

EIN#: _____

Organization's Advertising Name (*Name used for clients*) _____ (_____) _____
Phone # for Client Calls

Legal Name (*Name currently incorporated under*) _____ (_____) _____
Business phone #

Physical Street Address _____ City, State, Zip _____

Mailing/Billing Address _____ City, State, Zip _____

General Email Address _____ Client and/or Donor website _____

Name of Primary Contact / Job Title _____ Email address of Primary Contact _____

Hours of operation:

_____ By Appointment Only: ☐ Yes ☐ No

Payment options (if applicable):

1. **Check:** Make checks payable to: Heartbeat International.

2. **Credit Card:** Visa/MC # _____ Expiration Date _____

Billing address if different from above: _____

Signature _____

Note: The information in section II is primarily used for statistical analysis and aggregate reporting. The information in Section I may be shared with others.

I. Please check all the services below which your organization *directly* provides:

- | | |
|--|--|
| <input type="checkbox"/> Abortion Pill Reversal – Consulting Only | <input type="checkbox"/> On-Site Dr - Prenatal Care (Medical Service) |
| <input type="checkbox"/> Abortion Pill Reversal – Prescribing | <input type="checkbox"/> On-Site Ultrasound Services (Medical Service) |
| <input type="checkbox"/> Adoption Agency | <input type="checkbox"/> Parenting Classes |
| <input type="checkbox"/> Adoption Support | <input type="checkbox"/> Peer Counseling |
| <input type="checkbox"/> After Abortion Support | <input type="checkbox"/> Perinatal Hospice |
| <input type="checkbox"/> Childbirth Preparation Classes | <input type="checkbox"/> Pregnancy Tests (Medical Service) |
| <input type="checkbox"/> College Campus Satellite | <input type="checkbox"/> Self-Pregnancy Testing |
| <input type="checkbox"/> Community Referrals/Networking | <input type="checkbox"/> Resale/Thrift/Store |
| <input type="checkbox"/> Incentive Programs | <input type="checkbox"/> Sexual Integrity Program™ |
| <input type="checkbox"/> Material Aid/Baby Supplies | <input type="checkbox"/> STD Testing (Medical Service) |
| <input type="checkbox"/> Maternity Homes | <input type="checkbox"/> STD Treatment (Medical Service) |
| <input type="checkbox"/> Men's Program/Mentorship | |
| <input type="checkbox"/> Mobile Unit (Medical/Counseling) | |
| <input type="checkbox"/> Off-Site Partnership with Physician/Ultrasound Provider | |

II. Please answer the following questions:

1. Year your ministry began: _____
2. List any other National or State Associations that you are currently affiliated with: _____

3. Please list language(s) spoken by staff in your organization and are available for clients to receive counseling and/or services in: _____
4. Number of active volunteers (counselors, board members, unpaid “helpers”): _____
5. Number of unique clients served last calendar year: _____
6. Number of total client visits last calendar year: _____
7. Approximately what is your operating budget for the current year? _____
8. Check appropriate box if you receive any funding from ☐State ☐Federal ☐Medicaid
9. Do you have on-site medical services at your center? ☐Y ☐N
Medical Director: _____ Email: _____
Nurse Manager: _____ Email: _____

Note: As an affiliate of Heartbeat, our agency or organization subscribes to the Heartbeat Principles and to “Our Commitment of Care and Competence.” (Go to <https://www.heartbeat-services.org/about-us/why-affiliate/ready-to-affiliate>). We recognize that we are autonomous in all other matters of policy and management. This includes choice of name, method of operation, and all other matters which do not violate the principles of Heartbeat International. We expressly agree that Heartbeat International's Legal Consultant does not act as our legal counsel, and cannot represent us in legal proceedings or give us legal advice.

The undersigned certifies that he/she is qualified to sign on behalf of the corporation.

Signature of Board Member or Director: _____ Date: _____

III. Please attach the following:

- ☐ **Names, addresses, phone numbers, hours, and emails of your satellite offices.** This will ensure they are included in the Worldwide Directory as well as receive Heartbeat affiliate mailings, e-Blasts, and e-Bulletins.
- ☐ **Names and emails of your key staff and board members** so each can directly receive e-publications like the *Pulse* newsletter, e-Blasts, and e-Bulletins. The best board members are those equipped, envisioned, and encouraged for this great work. (*Heartbeat keeps individual contact information confidential.*)