A.P.A.R.T Membership Application

Name:

Street Address:

City, State, ZIP:

Phone:

Email:

**A.P.A.R.T Mission Statement: To expand recovery services for substance use throughout the state of Arkansas. To develop, implement, and evaluate state-wide efforts to broaden recovery and awareness.**

I agree with and support the mission statement of this coalition:

Signature & Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please select which Sub-Committee or Focus Workgroup you would like to serve.

O Policy & Procedures O Education O Outreach

O Recovery Services O Youth Outreach O Media/Marketing