



PO Box 567, Ojai, CA 93024, USA

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NATURAL PRODUCTS PROGRAM APPLICATION

DATE: _____

NAME OF ORGANIZATION OR AGENCY: _____

ARE YOU A TAX-EXEMPT ORGANIZATION? YES NO Tax I.D. # _____

WHAT TYPE OF ORGANIZATION? City or County Services Faith Based Organization
 Homeless Services Community Outreach Medical Clinic Other: _____

WHAT SERVICES DOES YOUR ORGANIZATION PROVIDE? _____

HOW DID YOU HEAR ABOUT NOURISH AMERICA? _____

HEAD OF ORGANIZATION

NAME: _____ TITLE _____

PHONE _____ FAX _____

EMAIL: _____ WEBSITE ADDRESS: _____

OFFICIAL CONTACT PERSON FOR YOUR NOURISH AMERICA PROGRAM:

NAME: _____ TITLE: _____

PHONE _____ EXT _____ FAX: _____

*EMAIL ADDRESS:(PRINT CLEARLY): _____

*In order for the program to remain cost effective, we require a viable, working email address for the contact person. Email is our primary way of communicating with our sites.

SHIPPING ADDRESS (FOR THE VITAMINS) Note: This must be a business address on a ground floor.

BUSINESS NAME: _____

ATTENTION: _____

ADDRESS: _____

CITY _____ STATE _____ ZIP _____ - _____

Phone _____ Fax _____

Please fill out both pages ⇒

PLEASE LIST ALL SITES OR LOCATIONS THAT WILL PARTICIPATE IN THE NOURISH AMERICA PROGRAM.

- If you need to list more than 5 locations – please make copies of this page.
- Give the number of participants at each location, as well as a GRAND TOTAL of all participants (at the bottom of the list) who will receive natural products, each month.

1) SITE NAME: _____
 ADDRESS: _____ CITY _____ ST _____ ZIP _____

NUMBER OF CLIENTS AT THIS SITE (MONTHLY) TO BE IN THE PROGRAM: _____

2) SITE NAME: _____
 ADDRESS: _____ CITY _____ ST _____ ZIP _____

NUMBER OF CLIENTS AT THIS SITE (MONTHLY) TO BE IN THE PROGRAM: _____

3) SITE NAME: _____
 ADDRESS: _____ CITY _____ ST _____ ZIP _____

NUMBER OF CLIENTS AT THIS SITE (MONTHLY) TO BE IN THE PROGRAM: _____

4) SITE NAME: _____
 ADDRESS: _____ CITY _____ ST _____ ZIP _____

NUMBER OF CLIENTS AT THIS SITE (MONTHLY) TO BE IN THE PROGRAM: _____

5) SITE NAME: _____
 ADDRESS: _____ CITY _____ ST _____ ZIP _____

NUMBER OF CLIENTS AT THIS SITE (MONTHLY) TO BE IN THE PROGRAM: _____

TOTAL NUMBER OF CLIENTS (LISTED ABOVE) to participate in the program, each month: _____

Our agency requests program participation in the Nourish America’s free distribution program. We understand that, as a condition of eligibility to participate in this program, we must participate in the Nourish America™ Annual Survey. We also understand that if we choose to terminate our participation in the program (or are terminated) at any point, we are responsible for either distributing, or returning any remaining product provided by Nourish America at our expense.

We agree to the above conditions of participation: **YES** **NO**

NAME _____ DATE _____

TITLE _____

* SIGNATURE: _____

* Must be signed by an official, who is a legally authorized representative of the agency or organization (Exec. Director, President, Treasurer, etc.)

PLEASE FAX YOUR COMPLETED FORM TO NOURISH AMERICA AT (805) 715-9701. THANK YOU!