AHA ASSOCIATE MEMBERSHIP APPLICATION

Please complete this form and mail it with payment of your annual membership dues to:
American Hospital Association
P.O. Box 92247, Chicago, Illinois 60675-2247

American Hospital Association

Organization

Street

City/State/ZIP Code/Country

Telephone Facsimile Website

Organization's primary service (e.g. consulting; telecommunications; medical supplies)

Name/Title to whom mail is to be directed

Mailing address if other than above

E-mail address

Name to whom second subscription is to be directed

Mailing address if other than above

E-mail address

Please select one:

☐ **Associate Advantage Member**	$10,000
☐ **Associate Member**	$ 2,950
☐ **Associate Member – International Organizations, Degree-Granting Health Education Programs**	$ 500

Membership dues are for the calendar year (January – December). Dues are prorated by the quarter for less than full year membership. Please call AHA Member Relations for a dues quote for memberships beginning after March 1.

☐ Check Payable to the American Hospital Association is enclosed.
☐ Please charge my credit card: ☐ VISA ☐ MasterCard ☐ American Express

Account number Expiration date

Cardholder's signature

As a member, do you wish to receive a complimentary subscription to Hospital & Health Networks? ☐ Yes ☐ No
Publications also included as part of Associate member benefits (*AHA, News, AHA Guide,* and *Hospital Statistics*) are valued at $725.

The organization makes application for Associate Membership in the American Hospital Association by submitting the information on this form for consideration.

Applicant's Signature

Title Date

We look forward to welcoming you to AHA membership. If you have questions, please call **AHA Member Relations at (312) 422-2750**.