



APPLICATION FOR AFFILIATE MEMBERSHIP

Name of Firm:	_____				
Name of Representative:	_____				
Title:	_____	Phone:	_____		
E-mail address:	_____	Website:	_____	Fax:	_____
Address:	_____	Zip	_____		
Mailing Address (if different from above):	_____	Zip	_____		
Business Description:	_____				
Reason for Applying:	_____				
Please list your areas of expertise:	_____				
Signature:	_____	Date:	_____		
Sponsor's Name (if applicable):	_____				

Affiliate Membership provides the opportunity to:

- *Receive notification of all Association educational institutes, workshops and seminars*
- *Participate in the Association Annual Membership Meeting*
- *Network with industry leaders and management*
- *Receive complimentary copies of Association publications*
- *Access to the Association's health-related legislation tracking*

DUES: Annual Affiliate Membership Dues are \$500.00. The annual period runs from July 1 – June 30. Dues are pro-rated by quarter if membership is approved after first quarter of the fiscal year. Please note: Membership is not effective until dues are received.