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:

- Access free or reduced-price education
- Participate in the Association’s Annual Membership Meeting
- Network with industry leaders and management
- Receive Association communications, including our weekly e-newsletter
- Receive complimentary copies of Association publications, studies, and survey results
- Access member-only reports and data
- Online listing in Association Membership Directory
- Post job openings on Association website

DUES: Annual Affiliate Membership Dues are $500.00. The annual period runs from July 1 - June 30. Dues are pro-rated by quarter based on when the application is submitted (July to September $500; October to December $375; January to March $250; April to June $125). Include dues check payable to the Healthcare Association of Hawaii with your application. Payment by credit card is available upon request, contact HAH to provide credit card information. Payment will only be deposited/processed if the application is approved.

HAH does not discriminate on the basis of race, color, religion, gender, gender expression, age, national origin (ancestry), disability, marital status, sexual orientation, or military status.