NATIONAL ASSOCIATION OF HEALTH SERVICES EXECUTIVES
1050 Connecticut Avenue, NW • 10th Floor • Washington, DC 20036 • 202-772-1030 • 202-772-1072 Fax

Join NAHSE online! - www.nahse.org

Application for Institutional Membership

Institutional members are organizations and agencies which are interested in and support the programs, aims and goals of NAHSE and are desirous of contributing to its cause, either in the form of financial support or other in-kind aid. The rights and privileges of the institutional members are determined solely by the Board of Directors. Institutional members are members of the Local Chapter with the approval and under the guidelines set down by the Local Chapter. Institutional members are to include organizations such as hospitals, medical centers, neighborhood health centers, group practices, health insurance companies, managed care, coordinated care entities and all other such organizations supporting the purpose of NAHSE. Institutional members may indicate three individuals from their institution who will receive benefits as part of their institutional membership.

Please type or print legibly.

I. Institutional Information

Date _____/_____/_____

Please list general information for your institution here.

Has your institution previously been affiliated with NAHSE? ❑ Yes ❑ No

Name of Institution _____

Type of Institution _____

Address _____

City _____ State/Province _____

Zip/Postal Code _____ Country _____

Main Phone _____ Main Fax _____

Email _____ Institution Website URL _____

II. Primary Contact Person

Please indicate a primary contact person for your institution. The primary contact person may be one of the three individuals who your institution has indicated to receive NAHSE benefits.

Prefix _____ First _____ Middle _____

Last _____ Suffix _____

III. Institutional Member - 1

Preferred address for correspondence: ❑ Home ❑ Business

Preferred method of communication: ❑ Email ❑ Fax ❑ Phone ❑ Mail

Name _____ Title _____

Business Address _____ City _____

State/Province _____ Zip/Postal Code _____

Country _____ Business Phone _____

Business Fax _____ Primary Email _____

Home Address _____ City _____

State/Province _____ Zip/Postal Code _____

Country _____ Home Phone _____

Home Fax _____ Secondary Email _____

List all academic degrees earned

Undergraduate College/University _____

Major Subject _____ Degree (Abbrev.)_____

Graduate College/University _____

Major Subject _____ Degree (Abbrev.)_____

Doctoral College/University _____

Major Subject _____ Degree (Abbrev.)_____

Beginning with your most recent place of employment prior to your current position, list all previous positions in health care (up to two positions). Include residencies, fellowships, and internships.

Organization _____

City _____ State/Province _____

Title _____ Duration: Month/Year _____/_____ to _____/_____

Organization _____

City _____ State/Province _____

Title _____ Duration: Month/Year _____/_____ to _____/_____

List other affiliations with professional organizations, including offices held within each organization.

Organization _____ Offices Held _____

Organization _____ Offices Held _____

Organization _____ Offices Held _____

IV. Institutional Member - 2

Preferred address for correspondence: ❑ Home ❑ Business

Preferred method of communication: ❑ Email ❑ Fax ❑ Phone ❑ Mail

Name _____ Title _____

Business Address _____ City _____

State/Province _____ Zip/Postal Code _____

Country _____ Business Phone _____

Business Fax _____ Primary Email _____

Home Address _____ City _____

State/Province _____ Zip/Postal Code _____

Country _____ Home Phone _____

Home Fax _____ Secondary Email _____

List all academic degrees earned

Undergraduate College/University _____

Major Subject _____ Degree (Abbrev.)_____

Graduate College/University _____

Major Subject _____ Degree (Abbrev.)_____

Doctoral College/University _____

Major Subject _____ Degree (Abbrev.)_____

Beginning with your most recent place of employment prior to your current position, list all previous positions in health care (up to two positions). Include residencies, fellowships, and internships.

Organization _____
City _____ State/Province _____
Title _____ Duration: Month/Year _____/_____ to _____/_____
Organization _____
City _____ State/Province _____
Title _____ Duration: Month/Year _____/_____ to _____/_____

List other affiliations with professional organizations, including offices held within each organization.

Organization _____ Offices Held _____
Organization _____ Offices Held _____
Organization _____ Offices Held _____

V. Institutional Member - 3

Preferred address for correspondence: ❑ Home ❑ Business
Preferred method of communication: ❑ Email ❑ Fax ❑ Phone ❑ Mail
Name _____ Title _____
Business Address _____ City _____
State/Province _____ Zip/Postal Code _____
Country _____ Business Phone _____
Business Fax _____ Primary Email _____
Home Address _____ City _____
State/Province _____ Zip/Postal Code _____
Country _____ Home Phone _____
Home Fax _____ Secondary Email _____

List all academic degrees earned

Undergraduate College/University _____
Major Subject _____ Degree (Abbrev.) _____
Graduate College/University _____
Major Subject _____ Degree (Abbrev.) _____
Doctoral College/University _____
Major Subject _____ Degree (Abbrev.) _____

Beginning with your most recent place of employment prior to your current position, list all previous positions in health care (up to two positions). Include residencies, fellowships, and internships.

Organization _____
City _____ State/Province _____
Title _____ Duration: Month/Year _____/_____ to _____/_____
Organization _____
City _____ State/Province _____
Title _____ Duration: Month/Year _____/_____ to _____/_____

List other affiliations with professional organizations, including offices held within each organization.

Organization _____ Offices Held _____
Organization _____ Offices Held _____
Organization _____ Offices Held _____

VI. Membership Information and Dues

Institutional membership dues include national and local chapter membership dues for three individuals. Please indicate the appropriate local chapter for all three persons who will receive benefits as part of NAHSE institutional membership.

Local Chapter Member 1: _____
Local Chapter Member 2: _____
Local Chapter Member 3: _____

Dues

Institutional Dues	**Amount Enclosed**
$1,500	**$_____**

Method of Payment

❑ Check or Money Order Enclosed (Made payable to the **National Association of Health Services Executives**)

❑ Visa ❑ MasterCard ❑ American Express ❑ Discover

Account Number _____ Expiration Date _____

Card Holder's Name _____ Amount Charged $_____

Card Holder's Signature _____ Today's Date _____

VII. Checklist

Please place a mark in each box

❑ Completed Application
❑ Dues

Mail Application Materials to:

National Association of Health Services Executives
P.O.Box 759204
Baltimore, MD 21275-9204

www.nahse.org