

# 2012 Associate Membership Application

## CONTACT INFORMATION:

Organization / Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Contact Person & Title (for mailing list): \_\_\_\_\_

Email Address: \_\_\_\_\_ Website: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Tax ID: \_\_\_\_\_

Associate Membership Renewal for 2012

New Associate Membership Application.

(New members must be sponsored by a Member Owner or Administrator.)

Sponsor Name: \_\_\_\_\_

## DESCRIPTION OF YOUR COMPANY'S PRODUCTS OR SERVICES:

(This information will be printed in the 2012 Directory of Long Term Care Facilities)

\_\_\_\_\_

\_\_\_\_\_

Signature of Applicant

Date

## PAYMENT (\$500 per calendar year)

Check

Visa     MasterCard     American Express

Name on card: \_\_\_\_\_

CC#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

V-Code: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Signature: \_\_\_\_\_

## PLEASE RETURN FORM TO:

Arkansas Health Care Association  
Attn: Rachel Davis  
1401 W. Capitol Avenue, Suite 180  
Little Rock, AR 72201

rdavis@arhealthcare.com  
fax: 501/374.1077

\*Must be received no later than  
2/17/12 to be listed in  
membership directory.

