2017 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 2017

☐ 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 2017 Directory of Long Term Care Facilities if received by deadline.)

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______________________________ Signature of Applicant

______________________________ Date

PAYMENT ($750 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: Cat Hamilton
1401 W. Capitol Avenue, Suite 180
Little Rock, AR 72201

chamilton@arhealthcare.com
fax: 501/374.1077

*Must be received no later than 2/10/17 to be listed in membership directory.