2017 Associate Member Application

Company Name: _____

Address: _____ City, State: _____ Zip: _____

Phone: _____ Fax: _____ Website: _____

Contact Person: _____ Contact Person's Email: _____

Company Category (circle up to 3)

Management and Operations
Accounting
Cost Reporting/Billing
Consulting Services
Education and Training
Group Purchasing
Insurance/Risk Management
Legal Services
Marketing
Publishing
Technology
Financial Services

Maintenance
Engineering, Design & Architecture
Environmental Supplies & Services
Clothing/Uniforms
Flooring/Carpeting
Furniture
Heating & Cooling
Housekeeping/Laundry
Linens & Textiles
Medical Waste & Disposal Treatment
Restoration & Remodeling

Resident Care
Foodservice
Hospital Services
Medical Supplies & Equipment
Nutrition
Oral Health
Physician Services
Pharmaceuticals
Rehabilitation/Therapy
Security/Monitoring
Transportation
Wound Care
Laboratory

IHCA E-Newsletter Distribution List

Please include the following email address on the distribution list for the IHCA IMPACT and other electronic communications:

Name: _____ Email Address: _____ Title: _____

Name: _____ Email Address: _____ Title: _____

Name: _____ Email Address: _____ Title: _____

IHCA Associate Member Council

☐ Yes, I want to serve on and participate in meetings of the IHCA Associate Member Council

☐ I am unable to actively participate on the IHCA Associate Member Council at this time but would like to receive information on the council's activities

2017 Associate Member Dues (circle one) Standard Member - $500 ☐ **Key Member - $2,000** ☐

Dues for Associate Membership are collected on an annual basis and provide Associate Members benefits from the date of membership approval by the IHCA Board of Directors to December 31, 2017. Please be advised that pursuant to Federal tax law dues spent on lobbying and other related costs are not deductible for federal income tax purposes. The IHCA reasonably estimates that 29% of dues will be spent on lobbying costs for 2017.

Would you like to contribute a suggested $85 donation to the Indiana Health Care Foundation (IHCF)? Yes ☐ No ☐

Agreement and Payment

I understand that submission of this application is not a guarantee of IHCA membership and that this application must be approved by the IHCA Board of Directors. Approval of membership does not constitute endorsement by the IHCA of applicant or its products and/or services. I understand that membership benefits are only to be used by the applicant and its employees and that any misuse of membership rights and benefits may result in membership termination. If this application is approved, IHCA may use applicant's information in IHCA membership directories (both electronic and printed), and applicant consents to receive communications via regular mail, email, telephone, and/or fax sent by or on behalf of IHCA. **Payment of 2017 Associate Member Dues must accompany this application and will be processed upon receipt**. Payment will be refunded if membership is denied.

_____
Signature Date

Payment form: ☐ Check payable to IHCA ☐ MC ☐ Visa ☐ Amex
Card Number: _____
Name on Card: _____
Exp. CVV Number:
Billing Zip Code: _____

Send application with payment to: Indiana Health Care Association, One North Capitol, Suite 100, Indianapolis IN 46204
Attn: Kate Vaulter