



ASSOCIATE MEMBERSHIP APPLICATION

Associate Members are organizations that supply goods or services to hospice and/or palliative care programs and professionals, or those interested in keeping informed of the hospice industry. Associate Members are not providers of hospice and/or palliative care. Associate Membership is not available to organizations that serve patients or organizations that qualify for another category of NHPCO Membership including Provider Membership.

GENERAL INFORMATION

Organization Name _____

Contact Name _____ Title _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

E-mail _____ Web Site _____

NHPCO respects your privacy. NHPCO will not sell, rent or distribute your e-mail address to any outside organization. NHPCO intends to use this medium to communicate membership related notices and benefits, as well as NHPCO related services, such as conference information and NHPCO Marketplace product announcements and sales. If you would prefer not to be included in the e-mail distribution list please check the preceding box.

Company description (*up to 30 words*) _____

Please indicate your primary type of business (*please check only one box*)

- | | | |
|---|---|---|
| <input type="checkbox"/> Consultant | <input type="checkbox"/> Medical Supply | <input type="checkbox"/> Software Vendor |
| <input type="checkbox"/> Insurance/Risk Management | <input type="checkbox"/> National Association | <input type="checkbox"/> Staffing Agency/Service |
| <input type="checkbox"/> International Organization | <input type="checkbox"/> Pharmaceutical | <input type="checkbox"/> Other (please describe): _____ |
| <input type="checkbox"/> Legal Service | <input type="checkbox"/> Publisher | _____ |

What is your primary reason for joining NHPCO? _____

Associate Membership dues are \$650 per year (*based on anniversary date*).....\$ 650.00

My company wants to be listed in your online Organizational Members directory. I understand the additional cost is \$200.....\$ 200.00

TOTAL FEE \$

- Check Enclosed** (payable to NHPCO) CK# _____

Card Number

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 Exp. Date

--	--	--

Name on Card (Print) _____

Authorized Signature _____

(Office Use Only)

Type _____

ID# _____

Payment _____

Initial _____

Date _____

I hereby certify that my organization is not a hospice, and that everything stated in this form is correct and complete to the best of my knowledge.

Name of Person Completing Form (Print) _____

Signature _____ Date _____

I want to make the most of my membership and gain access to NHPCO members! Please send me additional information on the following opportunities:

- Advertising Exhibits Sponsorships

Please return this form with payment to:

NHPCO, Department 929, Alexandria, VA 22334-0929 or fax to 703-837-1233

Questions? Call NHPCO's Membership Department at

800-646-6460