





Section A. Contact Information

Primary Contact*: _____ Title: _____
 Company: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____
 Email: _____
 President/CEO *: _____ Email: _____
 Date President/CEO (President, CEO, Executive Director, etc.) assumed this position? (MM/YY) ____/____
 Has this individual had prior experience at the President/CEO level for other hospices? Yes No
 If yes, please indicate years of experience: Less than One Year One–Two Years Three–Five Years Over Five Years
**Individual who will receive all Provider mailings from NHPCO, be listed as the as the primary contact on the NHPCO Web site and Membership Directory, serve as Voting Delegate and receive complimentary NCHPP membership.*

Section B. 2011 Palliative Care Provider Dues and Optional Services

2011 Palliative Care Provider Membership Dues \$ 500.00
 Palliative care Providers can add multiple locations to their membership for only \$200 per location (Number of multiple locations x \$200) \$ _____
Optional “Material Safety Data Sheets” (MSDS) Program  **MSDSonline®** \$ 55.00
Lowered Fees for the MSDS Program. Participation in the MSDS program is voluntary, however, OSHA requires that health care agencies have on hand for each hazardous chemical or cleaning product they use, a data sheet from the manufacturer that lists the potential hazards and health effects, and describes the measures to take in case of an emergency. **NHPCO has partnered with a new company to provide you with your MSDS form online.**
 Yes, I want my program(s) to enroll in the on line MSDS Program through December 31, 2011. PLEASE COMPLETE FORM ON NEXT PAGE. I understand that I am acquiring these services at a special member rate; non-member price is \$350.
Optional Subscription to *Journal of Pain and Symptom Management*, Official Journal of NHPCO \$ 160.00
 Yes, sign me up for a one-year subscription (12 issues) to the *Journal of Pain and Symptom Management*. I understand that I am receiving a special NHPCO member price; the institutional price is \$813 and the personal subscription price is \$292.
Optional Donation to the Hospice Action Network  \$ _____
 Yes, I want to make a tax-deductible donation. HAN was founded by NHPCO to bolster our existing lobbying presence in Washington. Your donation will support the HAN mission: To mobilize additional lobbying resources on the issues of greatest concern to members of NHPCO.
Total Amount Due for 2011 Membership Dues & Optional Services: \$ _____

Section C. Payment Instructions

Please mail payment with completed forms to NHPCO. Make a copy of all forms for your records. **Federal Tax ID 541096334.**

<input type="checkbox"/> My check is enclosed in full. Check Number: _____ Amount Included \$ _____ (made payable to NHPCO) <input type="checkbox"/> Please charge my: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express Credit Card # _____ Exp Date _____ Name on Card _____ Signature _____	<p style="text-align: center;">(Office Use Only)</p> Batch # _____ ID # _____ CC Auth _____ Initial _____ Date _____
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Everything stated in this form is correct and complete to the best of my knowledge.

Signature of person who completed form: _____
 Please print name: _____ Date: _____

**Membership dues are non-refundable. Please note that 96% of your dues payment may be tax deductible as an ordinary and necessary business expense. Approximately 4% of your membership dues payment will go towards lobbying efforts and is not tax deductible. This information is not intended as tax advice. Please contact your tax professional for tax advice.*



2011 NHPCO PALLIATIVE CARE ACTIVATION FORM

2011 MATERIAL DATA SAFETY SHEET (MSDS) REGISTRATION FORM

With the MSDS online, it is crucial that the Primary Contact be listed, and that an actively used email address be provided on this form. The system will allow you to track all of your MSDS forms electronically. You will be assigned a user id and a password to gain access to the Web site.

Primary Location:

Primary Contact _____ Title _____
Email Address (required) _____
Company _____ Provider ID# _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____

Second Location:

Primary Contact _____ Title _____
Email Address (required) _____
Company _____ Provider ID# _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____

Third Location:

Primary Contact _____ Title _____
Email Address (required) _____
Company _____ Provider ID# _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____

Fourth Location:

Primary Contact _____ Title _____
Email Address (required) _____
Company _____ Provider ID# _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____

Fifth Location:

Primary Contact _____ Title _____
Email Address (required) _____
Company _____ Provider ID# _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____

Sixth Location:

Primary Contact _____ Title _____
Email Address (required) _____
Company _____ Provider ID# _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____

For additional locations, please make a copy of this form



2011 NHPCO PALLIATIVE CARE ACTIVATION FORM

This form is used to report your agency's information. Upon renewing with NHPCO the information will be included in the NHPCO Directory, NHPCO's Web site and used for referral services. Fax the completed form to 703-837-1233, or mail with your Palliative Provider Activation Form to NHPCO, P.O. Box 34929, Alexandria, VA 22334-0929.

For each multiple location, please make copies and complete a separate Palliative Care Provider Verification Form (all pages must be completed).

Section A. Primary Contact Information

Primary Contact*: _____ **Title:** _____

Company: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

Email: _____ **Website:** _____

**NHPCO respects your privacy. NHPCO will not sell, rent or distribute your email address to any outside organization. NHPCO intends to use this medium to communicate membership related notices and benefits, as well as conference information and NHPCO Marketplace announcements.*

Do not list this program in the NHPCO Membership Directory or the "Find a Provider" section of NHPCO's Web site.

Section B. Program Information

1. My company is (choose one):

- Currently Operating a Palliative Care Program
 Currently Operating a Hospice AND Palliative Care Program
 Palliative Care Program in the Planning Stages

2. Dominant Corporate Status (choose one):

- | | |
|---------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Division of Veterans Administration |
| <input type="checkbox"/> Palliative Care Group Practice | <input type="checkbox"/> Division of Nursing Home |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Division of Prison |
| <input type="checkbox"/> Private Practice | <input type="checkbox"/> Other (HMO, PPO, DME, etc): _____ |
| <input type="checkbox"/> Division of Home Health Agency | |

3. Incorporation Status: Non-profit For-profit Government

4. Primary Financial Support:

- | | |
|---------------------------------------------|----------------------------------|
| <input type="checkbox"/> Parent Corporation | <input type="checkbox"/> Grants |
| <input type="checkbox"/> Philanthropy | <input type="checkbox"/> Billing |

5. Medicare Certified as a Hospice:

- Yes Medicare Provider Number: _____
 No

6. Medicaid Certified as a Hospice: Yes No

7. Do you have a Satellite site? Yes No

8. Total Paid Staff _____

9. Total Full Time Staff Equivalents _____

10. Total Volunteers _____

Section C. Program Services

11. Pediatric Palliative Care Active Program No Program Planning Stages

12. Inpatient Consultation Service Yes No

13. Inpatient Palliative Care Unit Yes No



2011 NHPCO PALLIATIVE CARE ACTIVATION FORM

14. Outpatient Palliative Care Service Yes No

15. Teaching Service:

A. Medical Yes No

B. Nursing Yes No

C. Social Work Yes No

D. Spiritual Care Yes No

E. Other (Please Specify): _____

Section D. Location Information (to provide accurate referrals)

16. MSA (Major Metropolitan Area) Please list **only one city name**: _____

17. Cities Served: NO MORE THAN 12; include the state abbreviation(s) if different than hospice locale:

Section E. Please update the following staff information – All staff members included here will be automatically enrolled as complimentary members of NHPCO and be part of the National Council of Hospice and Palliative Professionals (NCHPP)*

** The National Council of Hospice and Palliative Professionals (NCHPP) is NHPCO's individual membership category and is the voice for professionals, volunteers and interdisciplinary teams. NCHPP membership is a commitment to the development of hospice and palliative care professionals and advancement of quality end-of-life care. All volunteers and employees of NHPCO provider members are eligible for complimentary membership to NCHPP.*

Bereavement Coordinator:	E-mail**:
CNA Coordinator:	E-mail:
Communications Contact:	E-mail:
Community Outreach Contact:	E-mail:
Ethics Contact:	E-mail:
Federal Legislative Contact:	E-mail:
Medical Director:	E-mail:
Additional Medical Director:	E-mail:
MSDS Contact:	E-mail:
Nursing Staff Director:	E-mail:
PI/QA Contact:	E-mail:
Professional Education Contact:	E-mail:
Public Policy Contact:	E-mail:
Referral Contact:	E-mail:
Spiritual Caregiver:	E-mail:
Standards Contact:	E-mail:
Social Worker:	E-mail:
Volunteer Coordinator:	E-mail:

**** An e-mail address for each employee is required in order to log in to the NHPCO Web site and to receive membership communications and other benefits from NHPCO.**