



Associate Membership Application

Please indicate your level of membership:

<input type="checkbox"/> Corporate	\$500.00 / year	<input type="checkbox"/> Inactive Administrator	\$90/ 6 months
<input type="checkbox"/> Individual	\$275.00 / year	<input type="checkbox"/> Student	\$50.00 / year

Company/Individual _____

Street Address: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ Fax: (____) _____

Website address: _____

Type of Business: _____

Contact Person(s):

(1) _____ (2) Corp: _____

Title: _____ Title: _____

Email: _____ Email: _____

(3) Corp: _____

Title: _____

Email: _____

Authorized Signature: _____

Title: _____ Date: _____

West Virginia Health Care Association's Associate Membership annual dues are payable in advance. Please indicate your method of payment and enclose with application.

_____ Check (payable to West Virginia Health Care Association)

Credit Card: _____ Visa _____ Mastercard _____ Am Ex _____ Expiration Date: _____

Card number: _____ Print Name on Card: _____

Address on card: _____

Signature: _____