Associate Membership Application

Please indicate your level of membership:

❑ ***Corporate***	*$520.00 / year*	❑ ***Inactive Administrator***	*$90.00 Every 6 months*
❑ ***Individual***	*$275.00 / year*	❑ ***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: ____________________

Annual dues are payable in advance for Associate Members of the WV Health Care Association.
Please indicate your method of payment and enclose with application.

_______ Check *(payable to West Virginia Health Care Association)*
_______ Credit Card: ______ Visa _______ MasterCard ________ American Express

Card number: ____________________ Exp: ____________________

Signature: ______________________________

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