WEST VIRGINIA
Health Care
ASSOCIATION

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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