

AHP Affiliate Membership Application

Page 1 of 3

I heard about AHP from: _____

Please complete ALL 5 sections of the application and return ALL 3 pages of the application to AHP.

1. Membership Type (please select one):

AHP Affiliate Small Firm Membership

For firms with fewer than three employees. Membership dues are \$459 per year.

AHP Affiliate Membership

For companies, organizations, or individuals who provide consulting or other specialty services to health care institutions or health-related organizations. Membership dues are based on the number of staff you would like to receive benefits. See below affiliate membership dues chart for more information.

Affiliate Annual Membership Dues *

Staff	Dues
3	\$689
4-5	\$945
6-7	\$1,201
8-9	\$1,457
10-11	\$1,713
12 or more	\$1,841 plus \$128 for each additional staff

*All affiliate dues are due on October 1 of each year.

If you are joining on a date other than October 1, dues will be pro-rated. Contact AHP at (703) 532-6243 for specific information.

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AHP Affiliate Membership Application

Page 2 of 3

2. Membership Information

Company Name

Primary Contact

Please check: ___Ms. ___Mrs. ___Miss ___ Mr. ___ Dr. ___Other

Title

Mailing Address

City

State

Zip

Telephone

Fax

Email

Company's Web Address

Roster REQUIRED

Name of Primary Contact (if different from above): _____

Number of staff joining: _____

Attach additional sheets to list all staff at your company you would like to include on the membership, including all contact information (mailing address, phone, fax and email).

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AHP Affiliate Membership Application
Page 3 of 3

3. Company Description and Payment

<p>Please <u>select all</u> that describe your company.</p> <p><input type="checkbox"/> Consulting – Annual Giving</p> <p><input type="checkbox"/> Consulting – Capital Campaign</p> <p><input type="checkbox"/> Consulting – Fund-Raising</p> <p><input type="checkbox"/> Consulting – General</p> <p><input type="checkbox"/> Consulting - Planned Giving</p> <p><input type="checkbox"/> Direct Mail</p> <p><input type="checkbox"/> Donor Recognition/Awards</p> <p><input type="checkbox"/> Executive Recruiting</p> <p><input type="checkbox"/> Grant Writing</p> <p><input type="checkbox"/> Publishing</p> <p><input type="checkbox"/> Software</p> <p><input type="checkbox"/> Special Events</p> <p><input type="checkbox"/> Telemarketing</p> <p><input type="checkbox"/> Other: _____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p style="text-align: center;">INITIAL DUES MUST BE INCLUDED (PAYABLE IN U.S. FUNDS)</p> <p>My check for \$_____ is enclosed.</p> <p>Please charge \$_____ to:</p> <p><input type="checkbox"/> AMEX <input type="checkbox"/> Mastercard <input type="checkbox"/> VISA</p> <p>Account Number: _____</p> <p>Exp. Date: _____</p> <p>Signature: _____</p>
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**Member dues are not deductible as a charitable contribution but may be deductible as a business expense.*

Return this form with payment to:
Association for Healthcare Philanthropy
313 Park Avenue, Suite 400
Falls Church, VA 22046
(703) 532-6243, Fax: (703) 532-7170
E-mail: ahp@ahp.org, Web: www.ahp.org

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