

# AHP Membership Application

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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 Individual Membership

*Individual Membership* is available to those individuals employed by any voluntary, not-for-profit or government health care organization or institution whose responsibilities are directly related to resource development. Individual Membership is \$440. **Individual membership is non-transferable.**

### AHP Institutional Membership

*Institutional Membership* is available to any voluntary, not-for-profit or government health care organization or institution. **Membership dues are based on the number of development professionals on staff who should receive benefits.** See dues structure below for more information. Institutional memberships are transferable.

#### **Institutional Annual Membership Dues \***

Development Professionals	Dues
2-3	\$992
4-5	\$1,488
6-7	\$1,984
8-9	\$2,481
10-11	\$3,087
12 or more	\$3,337 plus \$250 for each additional member

\*All institutional dues are due on July 1 of each year.

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

### AHP Associate Membership

*Associate Membership* is available only to those individuals who are interested in the purposes, programs, or activities of the Association, but are not associated with a health care organization. This membership category also includes students. **Consultants and vendors are not eligible for this membership and should contact AHP for affiliate membership information.** Associate membership is \$315 and non-transferable.

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## 2. Membership Information

\_\_\_\_\_  
Name of Health Care Institution

\_\_\_\_\_  
Name

Please check:  Ms.  Mrs.  Miss  Mr.  Dr.  Other

\_\_\_\_\_  
Title

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Fax

\_\_\_\_\_  
Email

\_\_\_\_\_  
Institution's Web Address

### **For Institutional Membership *ONLY* — Roster *REQUIRED***

Name of Primary Contact (if different from above): \_\_\_\_\_

Number of development professionals joining: \_\_\_\_\_

**Attach additional sheets to list all development professionals** at your institution, including all contact information (mailing address, phone, fax and email). All development professionals must be included to qualify for institutional membership.

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### **3. Payment**

Initial Dues must be included with this application (payable in U.S. funds)

Enclosed is my check for \$ \_\_\_\_\_

Please charge \$ \_\_\_\_\_ to:

\_\_\_\_ Visa    \_\_\_\_ MC    \_\_\_\_ AMEX

Account Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Signature of Card Holder: \_\_\_\_\_

### **4. Signature**

I am/we are applying for membership in the Association for Healthcare Philanthropy and will abide by its Bylaws, uphold its Statement of Professional Standards and Conduct, support its goals, and pay established annual dues.

Signature: \_\_\_\_\_

### **5. Mail ALL 3 pages of the application with payment to:**

Association for Healthcare Philanthropy  
313 Park Avenue, Suite 400  
Falls Church, VA 22046

### **Or fax ALL 3 pages to:**

703-532-7170 Fax

**\*Member dues are not deductible as a charitable contribution but may be deductible as a business expense.**

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