

# MEMBERSHIP APPLICATION

## Associate Type 8A Institutional



TEXAS HOSPITAL ASSOCIATION

*The Type 8A membership category in the Texas Hospital Association is for non-profit health care-related organizations, government health agencies, home health agencies and out-of-state hospitals.*

Organization Name \_\_\_\_\_

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

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (area code) \_\_\_\_\_ Fax (area code) \_\_\_\_\_

Location Address (if different from mailing address) \_\_\_\_\_

Web Site Address \_\_\_\_\_

Name/Title of THA Membership Representative (This individual will be THA's contact for your organization's membership. All mailings and communications will be sent to him/her.):

Briefly describe how your organization is related to the health care field:

Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_  
(Membership Representative)

Annual membership dues for Associate Type 8A Institutional Membership are \$250. The THA dues year for all members begins September 1 and ends August 31. At the time applicants are approved for institutional membership, they will pay dues for one full year.

Enclosed is a check for \$ \_\_\_\_\_, payable to THA.

I authorize THA to charge these dues to:  Visa  MasterCard  American Express

Account Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

Cardholder's Printed Name \_\_\_\_\_

Cardholder Signature (must be signed to charge) \_\_\_\_\_

Cardholder Billing Address (if different from above) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**SEND TO:** Membership Administration, THA, P.O. Box 679010, Austin, Texas 78768-9010 • Telephone 512/465-1000

<b>THA USE ONLY</b>	
Received _____	Payment _____
I.D. _____	Effective Date _____