

MEMBERSHIP APPLICATION

Associate Type 8B Institutional



TEXAS HOSPITAL ASSOCIATION

The Type 8B membership category in the Texas Hospital Association is for for-profit health care-related organizations, including suppliers of services and/or products to the health care field.

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 8B Institutional Membership are \$3,000. 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

THA USE ONLY

Received _____ Payment _____

I.D. _____ Effective Date _____