



NEW ASSOCIATE MEMBER APPLICATION FORM

MEMBERSHIP INFORMATION (information listed below will be used in the membership directory as well as on the website)

Date of Application: _____

Organization: _____

Address: _____

City/State/Zip: _____

Web site: _____

Phone: _____ Fax: _____

Name of Chief Executive Officer: _____

Contact Person: _____

Contact Title: _____

Contact E-mail: _____

PRIMARY BUSINESS PRODUCT/SERVICE (please select by typing an ✓ in the appropriate box or boxes)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Advertising Agency | <input type="checkbox"/> Education | <input type="checkbox"/> Insurance | <input type="checkbox"/> Promotional Items |
| <input type="checkbox"/> Accounting | <input type="checkbox"/> Elderly/In Home Care | <input type="checkbox"/> Interior Design | <input type="checkbox"/> Real Estate |
| <input type="checkbox"/> Account Receivables | <input type="checkbox"/> Financial/Benefit Services | <input type="checkbox"/> Legal | <input type="checkbox"/> Rehabilitation Facility |
| <input type="checkbox"/> Architecture/Construction | <input type="checkbox"/> Food Service | <input type="checkbox"/> Management/
Information Consulting Services | <input type="checkbox"/> Signage |
| <input type="checkbox"/> Billing Services | <input type="checkbox"/> Group Purchasing | <input type="checkbox"/> Marketing/Research | <input type="checkbox"/> Staffing/Recruitment |
| <input type="checkbox"/> Blood Products | <input type="checkbox"/> Health Care Furnishings | <input type="checkbox"/> Medical Equipment/Management | <input type="checkbox"/> Therapy Services |
| <input type="checkbox"/> Cancer Services | <input type="checkbox"/> Health System | <input type="checkbox"/> Nurse Call Systems | |
| <input type="checkbox"/> Child Care | <input type="checkbox"/> Heating/Cooling System | <input type="checkbox"/> Organ Recovery | |
| <input type="checkbox"/> Collection Services | <input type="checkbox"/> Information Technology
Consulting/Software | <input type="checkbox"/> Patient Satisfaction | |
| <input type="checkbox"/> Data Analysis | | | |

GENERAL INFORMATION

Please furnish a brief statement explaining principal function and purpose of your organization and its relationship to Iowa's health care industry. (400 character maximum, this includes spaces)

*The price for a membership is \$925; full payment is required for membership to be processed.

Please mail your payment (and agreement in not submitting online) to:

Iowa Hospital Association | 100 East Grand Avenue, Suite 100 | Des Moines, IA 50309-1835 | Fax: 515.698.5131
For more information, contact Crystal Peters, at 515.288.1955 or petersc@ihaonline.org.