

Application for Associate Membership

Please attach a separate sheet if you need more space.



VIRGINIA HOSPITAL
& HEALTHCARE
ASSOCIATION

An alliance of hospitals and health delivery systems

Company	Year Established
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Street Address	City	State	Zip
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Mailing Address	City	State	Zip
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Phone	Fax	Web Site
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Primary Contact	Title	E-mail
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Additional contacts who will be involved with the association

Name	Title	E-mail
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Name	Title	E-mail
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Name	Title	E-mail
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Type of business/organization

Brief description of products/services provided

Association, affiliation, etc., with Virginia hospitals (names of clients, customers and/or hospitals served)

Reason for applying for association membership

Why and how can your company support and further the policy aims of hospitals and health systems and the communities they serve?

It is understood that before becoming a member, dues, in the amount of \$1,000 annually, must be remitted. It also is understood that this completed application will be referred to the Executive Committee for consideration. After action by the Executive Committee and the Board of Directors, the applicant will be notified by letter.

Signature of Applicant	Title	Date
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Please return to:
VHHA • P.O. Box 31394 • Richmond, VA 23294-1394
(804) 965-1209