

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

Street Address City State Zip

Mailing Address City State Zip

Phone Fax Web Site

Primary Contact Title E-mail

Additional contacts who will be involved with the association

Name Title E-mail

Name Title E-mail

Name Title E-mail

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 \$1,500 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

Please return to:
VHHA • P.O. Box 31394 • Richmond, VA 23294-1394
(804) 965-1219 or jwalker@vhha.com