MISSOURI HOSPITAL ASSOCIATION
NON-MISSOURI DISTRICT MEMBERSHIP APPLICATION

Submit to:
MISSOURI HOSPITAL ASSOCIATION
P.O. BOX 60
JEFFERSON CITY, MO 65102-0060

DATE _____

Name of Institution: _____

Street Address: _____

Mailing Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Name of Chief Executive Officer: _____

Title and credentials (M.D./MHA/FACHE/Mr./Ms.): _____

E-mail: _____

Type of Facility:

_____ General Acute Care _____ Rehabilitation

_____ Psychiatric _____ Other (Specify: _____)

Type of Ownership: (Check all that apply.)

_____ Not-For-Profit _____ Public _____ State _____ County

_____ Investor-Owned _____ Federal _____ City _____ District

Management contract (duration and with whom): _____

_____

Federal tax I.D. number: _____ Number of licensed beds: _____

Number of physicians employed: _____

Is the facility a Medicare provider? _____ Yes _____ No If yes, provider number: _____

Is the facility part of a health system or network(s)? _____ Yes _____ No

If so, describe _____

_____

Check accreditation(s)/certification(s):

_____ DHSS _____ CARF _____ CIHQ _____ DNV _____ AAHHS

_____ The Joint Commission _____ Medicare _____Medicaid

List other memberships the institution holds or other associations to which the institution belongs:_____

_____

_____

Please attach a list of senior staff and their titles to facilitate efforts to assist the institution's management team, and provide the names of the facility's board members below.

Chairman/President: _____

Vice President: _____

Secretary: _____

Treasurer: _____

Others: _____

This institution understands that this district membership application is subject to approval by the Missouri Hospital Association Board of Trustees.

Signed: _____

Title: _____

Date: _____

Date Received:_____ Date Approved: _____