MISSOURI HOSPITAL ASSOCIATION
INDIVIDUAL MEMBERSHIP APPLICATION

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

DATE _____

Name of applicant or chief executive: _____

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

Name of Company/Organization:_____

Street Address:_____

Mailing Address:_____

City/State/Zip:_____

Phone:_____E-mail:_____Fax:_____

Please describe the corporate/organizational makeup and services offered by the company/organization:_____

_____

_____

Type of ownership or control:

_____ Not-For-Profit Corporation
_____ For-Profit Corporation
_____ Professional Corporation
_____ Partnership
_____ Sole Proprietor
_____ Public Agency

Please list the company's/organization's federal tax I.D. number:_____

Please list other professional memberships you and the company/organization with which you are affiliated hold or other associations to which you or the company/organization with which you are affiliated belong:____

_____

_____

_____

I understand that individual members are non-voting members of the Missouri Hospital Association and that this application is subject to approval by the Missouri Hospital Association President.

Signed:_____

Title:_____

Date:_____

PAYMENT INFORMATION

❒ **CHECK** enclosed for $150 annual dues payable to Missouri Hospital Association.

❒ **CREDIT CARD** ___ MasterCard ___ VISA ___ American Express ___ Discover

Amount Authorized $_____

Card Number __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ Expiration Date ____ /____

Name on Card (please print) _____

Signature _____

Dues paid by credit card may be faxed — both sides of form — to 573/893-7665 or 573/893-2809.

Date Received:_____ Date Approved:_____

Approved By:_____
President