



APPLICATION FOR REGULAR PERSONAL MEMBERSHIP

NAME _____ TITLE: _____

HEALTHCARE FACILITY: _____

BUSINESS MAILING ADDRESS: _____

City State Zip (9-digit)

Business Telephone: () _____

Business Fax: () _____

E-Mail Address: () _____

Information e-mailed to members often is not available in any other format. We encourage you to provide an e-mail address if at all possible.

Residence Mailing Address: _____

City State Zip

E-Mail Address: () _____

Send E-Mails/Mailings to: Business Home

A check for \$30 made payable to THA is enclosed. An annual renewal invoice will be sent each year.

I understand that I must be employed by an institutional member of the Tennessee Hospital Association in order to be eligible for and retain regular personal membership.

DATE: _____

Signature

RETURN TO: THA Membership Records
500 Interstate Blvd. South
Nashville, TN 37210-4634
PHONE: 615-256-8240