

# APPLICATION FOR AFFILIATE MEMBERSHIP

*With the Tennessee Hospital Association*

I hereby make application for membership in the specified organization and submit the following required data for consideration by the Committee on Membership. **(Please check applicable organization)**

Tennessee Alliance of Hospital Attorneys	_____	\$ 50.00
Tennessee Association for Healthcare Recruiters	_____	\$ 75.00
Tennessee Association for Healthcare Recruiters Vendor Mbrship	_____	\$125.00
<b>(note: Vendor membership for individuals NOT employed by a hospital)</b>		
Tennessee Association for Healthcare Quality	_____	\$ 50.00
Tennessee Health Science Library Association	_____	\$ 40.00
Tennessee Hospital Engineers Association (for hospital employees)	_____	\$ 40.00
Tennessee Hospital Engineers Association Associate Mbrship	_____	\$ 80.00
<b>(for vendors)</b>		
Tennessee Healthcare Environmental Services Association	_____	\$ 60.00
Tennessee Organization of Nurse Executives	_____	\$ 75.00
<b>* (includes local chapter dues)</b>		
Tennessee Society for Healthcare Marketing and Public Relations	_____	\$ 60.00
Tennessee Society of Healthcare Materials Managers	_____	\$ 60.00
Tenn. Society of Healthcare Materials Managers Vendor Mbrship	_____	\$ 75.00
Tennessee Society of Directors of Volunteer Services	_____	\$ 55.00

**Note:** In order to provide your association with timely, accurate, and useable information, please complete **all** blanks below.

*(Please type or print)*

Name: Mr./Ms./Mrs. \_\_\_\_\_  
First Name Middle Name Last Name

Title: \_\_\_\_\_ Institution/Company: \_\_\_\_\_

**Who pays dues:** Hospital \_\_\_\_ Personal \_\_\_\_ *(This information is requested because of change of job status, etc.)*

**Where do you wish your mailings to be sent?** Hospital Address  Home Address

**Hospital/Company Address:** \_\_\_\_\_

Street Address

City, State, Zip

Work Number: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ E-mail Address \_\_\_\_\_

**(do not leave email blank)**

**Home Address:**

Street Address

City, State, Zip

Home Phone: (\_\_\_\_) \_\_\_\_\_ Home Fax: (\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

An applicant may join at any time during the year upon paying annual dues. Members will be billed for membership renewal fees by THA on his/her membership anniversary date.

## **REMITTANCE OF DUES MUST ACCOMPANY THIS APPLICATION !!**

Make check or money order payable to **Tennessee Hospital Association**, and send to:

**THA Accounting Department  
Tennessee Hospital Association  
500 Interstate Boulevard, South  
Nashville, TN 37210**

Revised Sept. 2006