2017 Sponsorship Application

CONTACT INFORMATION:

Organization / Company Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Contact Person & Title (for mailing list): _____

Email Address: _____ Website: _____

Telephone: _____ Fax: _____

☐ Sponsorship Renewal for 2017
☐ New Sponsorship Application.
(New members must be sponsored by a Member.)

Sponsor Name: _____

SPONSORSHIP LEVEL

*All levels include Associate Membership

☐ Diamond – $50,000
☐ Platinum – $25,000
☐ Gold – $15,000
☐ Silver – $10,000
☐ Bronze – $5,000
☐ Copper – $2,500

DESCRIPTION OF YOUR COMPANY'S PRODUCTS OR SERVICES:

(This information will be printed in the 2017 Directory of Long Term Care Facilities if received by deadline.)

_____

_____

_____ _____

Signature of Applicant Date

PAYMENT

☐ Check ☐ Invoice
☐ Visa ☐ MasterCard ☐ American Express

Name on card: _____

CC#: _____-_____-_____-_____

V-Code: _____ Exp. Date: _____

Billing Address: _____

City: _____ State: _____ ZIP: _____

Signature: _____

PLEASE RETURN FORM TO:

Arkansas Health Care Association
Attn: Cat Hamilton
1401 W. Capitol Avenue, Suite 180
Little Rock, AR 72201

chamilton@arhealthcare.com
fax: 501/374.1077

*Must be received no later than 2/10/17 to be listed in membership directory.

AHCA ARKANSAS HEALTH CARE ASSOCIATION

AALA ARKANSAS ASSISTED LIVING ASSOCIATION