2019 Associate Membership Application

CONTACT INFORMATION:

(This information will be printed in the AHCA/AALA Directory & Buyers Guide if received by deadline.)

Company Name: _____

Company Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

Website: _____

Contact Person & Title: _____

_____

Email Address: _____

Your social media names you would like us to include:

_____

Description of your Company's products or services:
(Attach additional page if necessary.)

_____

_____

_____

_____

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Tax ID: _____

☐ Associate Membership Renewal for 2019

☐ New Associate Membership Application
(New members must be sponsored by a Member.)

Sponsor Name: _____
(Required for New Members.)

_____

Signature of Applicant

_____

Date

ADDITIONAL CONTACTS:

1. Contact Name: _____
   Cell Phone: _____
   Email Address: _____
   Address *(if different)*: _____
   _____

2. Contact Name: _____
   Cell Phone: _____
   Email Address: _____
   Address *(if different)*: _____
   _____

3. Contact Name: _____
   Cell Phone: _____
   Email Address: _____
   Address *(if different)*: _____
   _____

PAYMENT ($750 per calendar year)

☐ Check

☐ Visa ☐ MasterCard ☐ American Express

Name on card: _____

CC#: _____-_____-_____-_____

V-Code: _____ Exp. Date: _____

Billing Address: _____

City: _____ State: _____ ZIP: _____

Signature: _____

Email Credit Card Receipt to:

_____

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 2/9/19 to be listed in the AHCA/AALA Directory & Buyers Guide.*

AHCA ARKANSAS HEALTH CARE ASSOCIATION

AALA ARKANSAS ASSISTED LIVING ASSOCIATION