

American College of Health Care Administrators

New Membership Profile Page

2007-2008 Membership Year

July 1, 2007- June 30, 2008



Contact Information

___ Dr. ___ Mr. ___ Ms. ___ Mrs. ___ Sr. ___ Rev. ___ Other

Name: _____ Credentials: _____
Title: _____
Facility/Company: _____
Provider Number: _____
Business Address: _____
City/State/Zip: _____
Phone: () _____ Fax: () _____
Corporation Name: _____ Number of Sites: _____
Home Address: _____
City/State/Zip: _____
Home Phone: _____
Work Email: _____ Personal Email: _____
Preferred Mailing Address: ___ Home ___ Office
Preferred E-mail Address ___ Home ___ Office

Demographic Data

Collection of this data will be used for statistical and survey purposes to improve and/or create programs and services to better serve you.

Date of Birth: _____

Gender: ___ Male ___ Female

Race: ___ American Indian ___ Caucasian ___ Hispanic
___ Afro-American ___ Other _____

Check all that apply to your role:

- | | |
|--|--|
| <input type="checkbox"/> Administrator (current) | <input type="checkbox"/> Executive Director |
| <input type="checkbox"/> Administrator (retired) | <input type="checkbox"/> Professor |
| <input type="checkbox"/> Administrator-in-Training | <input type="checkbox"/> Student |
| <input type="checkbox"/> Assistant Administrator | <input type="checkbox"/> Vendor/Service Provider |
| <input type="checkbox"/> CEO/COO/President | <input type="checkbox"/> Vice President/Director |
| <input type="checkbox"/> Consultant | <input type="checkbox"/> Owner |
| <input type="checkbox"/> Dept. Head/Manager | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Director of Nursing | |

Education:

(Check highest level attained)

- Doctoral degree
- Physician
- Masters degree
- Some graduate work
- Bachelor's degree
- Associate degree
- Diploma in nursing
- High school diploma

Clinical Background:

- LPN/LVN
- PT/OT/ST
- Registered Nurse
- Social Worker
- Other _____

Experience

Year you began working as an administrator: _____
Number of years in Skilled Nursing _____
Number of years in Assisted Living _____

Current License/National Certification

Date originally licensed _____
List license information:
State: ___ Number: _____ Type: _____
State: ___ Number: _____ Type: _____
State: ___ Number: _____ Type: _____

Profit Status of your facility:

- Private/For Profit
- Public/For Profit
- Not For Profit
- Government
- Other

Programs (check all that apply):

- Adult day care
- AIDS
- Alzheimer's/Dementia
- Assisted Living
- Complex medical
 - Head Trauma
 - Rehabilitation
 - Skilled Nursing
 - Subacute
 - Ventilator/or Pulmonary
 - Wound care
- Consulting
- CCRC
- Geriatric center
- Home health
- Hospice
- LTACH
- Mental health/ICF/MR
- Pediatrics
- Senior center
- University/Academia

Is your organization:
 Management group
 Hospital-based
 Independent Ownership
 Corporately Owned

- National Corporation
- Regional Corporation
- Local Corporation

 Integrated delivery system
 Other _____

of clients your organization cares for daily: _____

Communications Options (required)

On occasion, ACHCA may make its mailing list available to organizations whose products or messages we feel may be of interest to our members. Do you wish to be included in such mailings?

Opt-in _____ Opt-out _____

Third Party Fax communications: Opt-in _____

ACHCA will not make your phone or email address available to vendors or suppliers of services.

**American College of Health Care Administrators
New Membership Application
2007-2008 Membership Year
July 1, 2007- June 30, 2008**



A. National (Includes Chapter Dues of \$25.00):

Membership Category*	Received Between 6/1-9/1/07	Received Between 9/2-12/1/07	Received Between 12/2/07-3/1/08	Received Between 3/2/08-6/30/08
Full	\$273	\$205	\$137	\$69 + \$273 for '09=\$342
Affiliate	\$376	\$282	\$188	\$94 + \$376 for '09= \$470
Senior Retired	\$154	\$116	\$78	\$40 + \$154 for '09= \$192
Student**	\$66	\$50	\$34	\$16 + \$66 for '08= \$82

A. Dues

\$ _____ Dues from above
 \$ _____ Additional Chapter Dues @ \$25.00 per additional chapter; Name of chapter: _____
 \$ _____ \$25.00 Application fee applies to initial applications and lapsed renewals of 12 months or greater; Application fee is waived for Student Members
 \$ _____ Total Dues

B. Optional Tax Deductible Donations***

\$ _____ The Academy of Long Term Care Leadership and Development
 \$ _____ Fund Drive Donation
 \$ _____ Richard L. Thorpe Fellowship
 \$ _____ Sister Joan Cassidy & Michael Cuseo Cultural Diversity Endowment Fund
 \$ _____ W. Phillip McConnell Student Scholarship Fund
 \$ _____ Total Optional Donations

C. Total Payment:

\$ _____ A. Dues
 \$ _____ B. Optional Donations
 \$ _____ C. Total Remitted

* See description of membership categories in brochure
 **Applicant must submit proof of enrollment
 ***For information on ACHCA scholarships please visit www.achca.org

_____ I've enclosed a check payable to ACHCA.
 Check # _____

_____ Please charge my:
 _____ American Express _____ MasterCard _____ Visa
 Account Number: _____ Expiration Date: _____
 Name of Card Holder: _____
 Signature of Cardholder: _____

Send Your Application and Contact Information Page To:
 ACHCA Membership
 PO Box 75060
 Baltimore, MD 21275-5060

For questions contact:
 Katleen Bartnek-Gallagher
 Phone: 703-234-4082
 Fax: 703-435-4390
 E-mail: kb Gallagher@achca.org