



Minnesota Hospital Association

# Application for Associate Membership

Date: \_\_\_\_\_

Name of Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP+4 \_\_\_\_\_

Telephone \_\_\_\_\_ Fax: \_\_\_\_\_

Web site \_\_\_\_\_

Individual to whom mail is to be directed: \_\_\_\_\_

Email Address \_\_\_\_\_

Ownership: Public \_\_\_\_\_ For-profit \_\_\_\_\_ Non-profit \_\_\_\_\_

Purpose of organization and relationship to health care field: (Please enclose brochure or annual report describing your company.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that in becoming an Associate Member, the dues must be remitted as specified.

Signed \_\_\_\_\_ Title: \_\_\_\_\_

Annual Membership Dues (\$1,100) \_\_\_\_\_

TOTAL AMOUNT REMITTED: \_\_\_\_\_

Please return application and payment made payable to Minnesota Hospital Association, to Education/Associate Membership, Minnesota Hospital Association, 2550 University Ave. W., Suite 350-S, St. Paul, MN 55114-1900.