



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 describe in 2-3 sentences the purpose of your company and the services it provides to the health care industry.) _____

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.