



# Associate Membership Application

Date

Organization Name

Address

City  State  ZIP+4

Phone  Fax

Website

Business Category (please review the [list of MHA's business categories](#) and enter up to five below)

  
  
  
  

In 30 words or less, please briefly describe the purpose of your organization and the services it provides to the health care industry. This information will accompany your organization's listing in MHA's directory.

Primary contact for **membership renewal**

Name  Title

Phone  Email

Primary contact for **advertisement/sponsorship information**

Name  Title

Phone  Email

### Annual Membership Dues: \$1,500

Dues must accompany application to be approved. Dues will be prorated quarterly. Please contact [Jenny Sanislo](#), program coordinator/division assistant, MHA, for the appropriate dues amount to submit or with any questions.

Total amount remitted

I understand that in becoming an associate member, dues must be remitted as specified above.

Signed  Title

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