Minnesota Hospital Association

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 and accounts payable for invoices***

Name Title

Phone Email

Primary contact for ***advertisement/sponsorship information***

Name Title

Phone Email

Annual Membership Dues: ☐ **$7,500** ☐ **$2,000**

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, 161 Rondo Ave., Suite 1010, St. Paul, MN 55103-3454