



Regular /Associate Membership Application

The NHCA is an association of healthcare owned collections agencies and hospital business office collection personnel. This application should be completed by the collection agency Vice President, Director or Manager who will sever as the voting member of the agency. Please complete the following information, attach your check for the New Member processing fee and first year membership dues and mail to the address below.

Your application will be presented to the Board of Directors at the next meeting for approval. Thank you for your interest in the NHCA.

Agency Information:

Agency Name: _____

Mailing Address: _____

City/State/Zip _____

Telephone Number: (_____) _____ FAX: (_____) _____

Website Address: _____

Healthcare Parent: _____
Corporation

Date Agency: _____ Number of Hospitals Served: ____ Profit ____ Not For Profit ____
Incorporated

Member Information:

Circle One

Regular/Associate, Member Name: _____ Title: _____

Only one Regular Member per agency

Unlimited number of Associate memberships available.

Address: _____ Telephone: _____

Your Email Address: _____ Years in Healthcare collections: _____

Please attach any marketing information or website information that will help us understand your agency better.

I certified that the agency submitting this application for membership is owned by a healthcare organization.

(Signature)

(Date)

(Please Print Your Name)

New member Applications Fee:	\$ <u>100.00</u> (New Regular membership only)
Annual Membership Dues if Agency has 10 or Less FTE's: \$ 350.00	\$ _____
Annual Membership Dues if Agency has 11+ FTE's: \$ 450.00	\$ _____
Additional Members (Associate) ea. @ \$ 125.00 <i>Attach additional copies for each</i>	\$ _____
Total Enclosed	\$ _____

Mail to: NHCA/Membership, 1502 Williamson RD. NE Suite 100, Roanoke, VA. 24012