Arizona Health Care Association
Business Affiliate Membership Application

Dues $699 Per Year

Company Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Corporate Representative:_____

Title:_____

Email: _____Website: _____

CEO's Name:_____

Company Category (please mark all that apply):

- ☐ Accounting
- ☐ Architecture
- ☐ Care Management
- ☐ Claims
- ☐ Consulting
- ☐ Dietary/Food Service
- ☐ Equipment
- ☐ Financial
- ☐ Funeral Home
- ☐ Furniture
- ☐ Group Purchasing
- ☐ Home Health
- ☐ Hospice
- ☐ Hygiene Products
- ☐ Insurance
- ☐ IT
- ☐ Janitorial
- ☐ Laboratory
- ☐ Laundry
- ☐ Legal
- ☐ Management
- ☐ Medical Supplies
- ☐ Non-Medical Home Care
- ☐ Pest Control
- ☐ Pharmaceuticals
- ☐ Pharmacy
- ☐ Physicians
- ☐ Placement Agency
- ☐ Program Contractor
- ☐ Public Relations
- ☐ Quality Assurance
- ☐ Radiology
- ☐ Rehabilitation
- ☐ Respiratory
- ☐ Restoration/ Construction
- ☐ Safety
- ☐ Security
- ☐ Staffing
- ☐ Transportation
- ☐ Utility
- ☐ Vascular Access
- ☐ Wound Care
- ☐ Other:_____ _____

Product/Service:_____

What are you looking for from your AHCA membership?_____

_____

Date: _____ Referred By: _____

Who is the main contact person from your company? Please provide their contact information:

Representative's Name: _____

Title: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____Fax: _____

Email: _____

Signature:_____

Mail this application to: Arizona Health Care Association, 1440 East Missouri Avenue, Suite C-102, Phoenix, AZ 85014-2458. Phone: 602.265.5331 Fax: 602.265.4401