



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):

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

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: \_\_\_\_\_