

Please fill out the application and return with payment to:

AHP Membership Services
313 Park Avenue, Suite 400
Falls Church, VA 22046

Find out more at
www.ahp.org

PRIMARY CONTACT INFORMATION

Name _____

Title _____

Company Name _____

Address _____

City _____

State/Province _____ Country _____ Zip _____

Email _____

Twitter _____ Fax _____

Office Phone _____ Mobile _____

Billing Contact Name _____

Billing Contact Title _____

Billing Contact Email _____

Billing Contact Phone Number _____

I would prefer to not receive 3rd party communications.

INSTITUTIONAL DEMOGRAPHICS

Name of Healthcare/Hospital System *(if applicable)* _____

Chief Executive Officer _____

Institutional Web Address _____

Number of Beds _____ Not Applicable

Service Population *(estimate)* _____

When is your fiscal year end _____

Geography

- Local Rural State
- Metropolitan Regional National

Program Size

- Small Large
- Mid-size Regional Network

Healthcare Facility Type

- Children's Hospital Long Term Care System
- Community Hospital Med. School Teaching
- Community Med. Ctr. Nursing/Retirement Home Tertiary Hospital
- Government Psychiatric University Based
- Hospice Safety Net/Public Hospital VNA

Institutional Membership is for any voluntary, not-for-profit, or governmental health care organization or institution. The membership dues are based on the number of development professionals on your membership roster. Only those on the membership roster with AHP receive member benefits and access. Membership is for 12 months and begins the month after your application and dues are received.

ANNUAL DUES (US)

- | | |
|-------------------------------------|---|
| <input type="checkbox"/> 2—\$976 | <input type="checkbox"/> 18—\$7,974 |
| <input type="checkbox"/> 3—\$1,872 | <input type="checkbox"/> 19—\$8,417 |
| <input type="checkbox"/> 6—\$3,206 | <input type="checkbox"/> 20—\$8,860 |
| <input type="checkbox"/> 9—\$4,480 | <input type="checkbox"/> 21—\$9,303 |
| <input type="checkbox"/> 12—\$5,316 | <input type="checkbox"/> 22—\$9,746 |
| <input type="checkbox"/> 13—\$5,759 | <input type="checkbox"/> 23—\$9,775 |
| <input type="checkbox"/> 14—\$6,202 | <input type="checkbox"/> 24—\$9,960 |
| <input type="checkbox"/> 15—\$6,645 | <input type="checkbox"/> 25—\$10,000 |
| <input type="checkbox"/> 16—\$7,088 | <input type="checkbox"/> 26—\$10,348 |
| <input type="checkbox"/> 17—\$7,531 | <input type="checkbox"/> + 398 per additional |

VOLUNTARY CONTRIBUTIONS (US)

Your gift makes a difference. Support the AHP Foundation today! Visit www.ahp.org to learn more about these scholarships. AHP Foundation scholarships help deserving members attend an AHP conference. Give back to the profession by making a contribution today!

- | | |
|-------------------------------|--------------------------------------|
| <input type="checkbox"/> \$25 | <input type="checkbox"/> \$100 |
| <input type="checkbox"/> \$50 | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> \$75 | |

METHOD OF PAYMENT

- Check/Money Order Mastercard
(Payable to AHP) AmEx
- Visa

Account Number _____

Exp. Date *(MM/YY)* _____

Signature _____

Date _____

For your convenience, payment for membership dues may be made to AHP by mail, phone, fax, or through AHP's website. Please note that AHP cannot control the handling of payment information sent to AHP by way of mail or email. AHP will not be responsible for any damages or loss incurred by you if you choose to send payment information (including, without limitation, credit card information) to AHP by way of mail or email. You therefore accept sole responsibility for any damage or loss resulting from your use of such communication methods. Please review our Privacy Policy found at http://www.ahp.org/Home/Home/Privacy_Policy/Home/Privacy_Policy.aspx for a summary of our practices related to the collection and use of personal information.

INSTITUTIONAL MEMBERSHIP ROSTER

Contact Information

Name _____

Title _____

Email _____

Twitter _____ Phone _____

I would prefer to not receive third party communications.

Personal Demographics

Date of Birth (MM/DD/YYYY) ___/___/___ Sex: Male Female

Year started career in development (i.e. 1995) _____

Year started career in health care development (i.e. 1995) _____

Primary responsibilities include (check as many as apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Annual Gifts | <input type="checkbox"/> Foundations/
Corporations | <input type="checkbox"/> Planned Giving |
| <input type="checkbox"/> Capital Campaigns | <input type="checkbox"/> Major Gifts | <input type="checkbox"/> Special Events |
| <input type="checkbox"/> Communications | <input type="checkbox"/> Marketing | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Direct Mail | | |

Primary Role (Select the primary role that best describes you. Select ONLY ONE.)

- | | | |
|--|--|---|
| <input type="checkbox"/> Administrative Assistant | <input type="checkbox"/> Database Manager | <input type="checkbox"/> Major Gifts Officer |
| <input type="checkbox"/> Annual Giving Officer | <input type="checkbox"/> Development Coordinator | <input type="checkbox"/> Planned Giving Officer |
| <input type="checkbox"/> Campaign Officer | <input type="checkbox"/> Development Officer | <input type="checkbox"/> President/CEO |
| <input type="checkbox"/> Chief Development Officer | <input type="checkbox"/> Director of Development | <input type="checkbox"/> Prospect Researcher |
| <input type="checkbox"/> Chief Financial Officer | <input type="checkbox"/> Donor Relations Coordinator | <input type="checkbox"/> Special Events Officer |
| <input type="checkbox"/> Chief Operating Officer | <input type="checkbox"/> Executive Director | <input type="checkbox"/> Vice President |
| | <input type="checkbox"/> Grant Writer | <input type="checkbox"/> Other _____ |

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