Individual Membership

Association for Healthcare Philanthropy

CONTACT INFORMATION

Name _____

Title _____

Company Name _____

Address _____

City _____ State/Province _____ Zip _____

Country _____

Email _____

Twitter _____ Fax _____

Office Phone _____ Mobile _____

☐ I would prefer to not receive 3rd party communications.

PERSONAL DEMOGRAPHICS

Year Born (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)*

- ☐ Annual Gifts
- ☐ Capital Campaigns
- ☐ Communications
- ☐ Direct Mail
- ☐ Foundations/Corporations
- ☐ Major Gifts
- ☐ Marketing
- ☐ Planned Giving
- ☐ Special Events
- ☐ Other_____

Primary Role *(Select the primary role that best describes you. Select ONLY 1.)*

- ☐ Administrative Assistant
- ☐ Annual Giving Officer
- ☐ Campaign Officer
- ☐ Chief Development Officer
- ☐ Chief Financial Officer
- ☐ Chief Operating Officer
- ☐ Database Manager
- ☐ Development Coordinator
- ☐ Development Officer
- ☐ Director of Development
- ☐ Donor Relations Coordinator
- ☐ Executive Director
- ☐ Grant Writer
- ☐ Major Gifts Officer
- ☐ Planned Giving Officer
- ☐ President/CEO
- ☐ Prospect Researcher
- ☐ Special Events Officer
- ☐ Vice President
- ☐ Other _____

INSTITUTIONAL DEMOGRAPHICS

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

Chief Executive Officer _____

Institutional Web Address _____

Number of Beds _____ ☐ Not Applicable

Service Population *(estimate)* _____

Geography

- ☐ Local
- ☐ Metropolitan
- ☐ Rural
- ☐ Regional
- ☐ State
- ☐ National

Program Size

- ☐ Small
- ☐ Mid-size
- ☐ Large
- ☐ Regional Network

Healthcare Facility Type

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

Individual Membership is available to individuals who are directly involved in fundraising and/or who are employed by any voluntary not-for-profit or government health care organization or institution. Membership is for 12 or 24 months and begins the month after your application and dues are received.

Please fill out the application and return with payment to AHP Membership Services at

313 Park Avenue, Suite 400
Falls Church, VA 22046

Fax: 703-532-7170

or apply online at
www.ahp.org/membership

ANNUAL DUES

☐ 12 Months—$498 ☐ 24 Months—$996

VOLUNTARY CONTRIBUTIONS

Your gift makes a difference. Support the AHP Annual Fund today!

- ☐ $25
- ☐ $50
- ☐ $75
- ☐ $100
- ☐ Other_____

METHOD OF PAYMENT

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

Account Number_____

Exp. Date *(MM/YY)*_____ cvc: _____

Name on Card_____

Signature _____

Date_____

For your convenience, payment for membership dues or benchmarking payments 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.