



Associate Member

Application for membership

An Associate Membership entitles my company/firm/organization to participate in the Iowa Health Care Association (IHCA) as an associate member, which excludes the right to vote in association affairs. IHCA will carry a listing of my organization's membership in the convention program book, newsletters and website to encourage patronage of my company/firm/organization. My Associate Membership will take effect upon approval by the IHCA Board of Directors. I understand that the Associate Membership will be automatically renewed each year, unless terminated in writing to the IHCA Vice President, Accounting & Member Services, and I will be billed for the yearly membership fee.

The per-calendar-year Associate Membership fee of \$750 must accompany this application. Mail check and application to IHCA, 1775 90th St., West Des Moines, IA 50266-1563.

Please type or print clearly

Date _____

Company name (as it will appear in IHCA records and publications)

Street address _____

Mailing address (if different) _____

City _____ State _____ Zip _____

With additional locations in these cities serving Iowa _____

Contact person _____ Title _____

E-mail _____ Phone (_____) _____

Website _____ Fax (_____) _____

Description of goods and/or services offered by company _____

Geographical area of state where company conducts business _____

Long term services and supports providers served (check all that apply)

NF____ AL____ RCF____ Senior Housing____ Home Health____ Adult Day____

Referred by IHCA member (optional) _____

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