Washington State Hospital Association

AFFILIATE MEMBERSHIP APPLICATION - Type IIIB

Type IIIB membership category in the Washington State Hospital Association is for **for-profit** health care-related organizations, including suppliers of services and/or products to the health care industry.

Organization Name_____

Mailing Address_____

City_____ **County**_____ **State**_____ **Zip**_____

Phone (area code) _____ **Fax** (area code) _____

Location Address (if different from mailing address) _____

Website Address_____ **Year Established** _____

1) Name/Title of WSHA Affiliate Member Type IIIB Representative. **This individual will be WSHA's contact for your organization's membership. All mailings and communication will be sent to this individual.**

Name_____ Title_____

Mailing Address (if different from mailing address above) _____

Email Address_____ Phone (area code) _____

2) Name/Title of WSHA Affiliate Member Type IIIB Representative. **This individual (if other than name provided above) will be WSHA's contact for your organization's renewal/receipt of invoice.**

Name_____ Title_____

Mailing Address (if different from mailing address above) _____

Email Address_____ Phone (area code) _____

Please provide a brief description of your organization or attach description

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☐ **I am interested in learning more about sponsorship opportunities at WSHA events**

Current WSHA Member Clients:

_____ _____

_____ _____

Annual Membership dues for Affiliate Member Type IIIB are $6,000.00. Affiliate membership is for the calendar year. Renewals begin January 1 for the following year. New organizations applying for Affiliate Membership after March 1 will have pro-rated dues. Once membership is approved by WSHA an invoice will be sent for the annual membership fee. Please complete application and submit to: Cynthia Hay, cynthiah@wsha.org, phone 206 216-2526.

For WSHA use only

Application Received Date:_____

Approval Signature:_____

Approved Date:_____

Invoiced Date:_____