

Institutional Membership Application for New Members

For the membership year January 1, 2017 through December 31, 2017

EMAIL COMPLETED FORM TO: membership@acha.org OR fax to (410) 859-1510 OR mail with check payment to American College Health Association, P. O. Box 419224 Boston, MA 02241-9224. Contact ACHA at (410) 859-1500 or membership@acha.org for questions.

I. GENERAL INFORMATION

Institution Name _____

Institution Mailing Address _____

City _____ State _____ Zip _____ Country (if not USA) _____

How did you hear about ACHA (e.g., colleague, internet, advertisement, etc.) _____

Reason(s) for joining ACHA (e.g., survey participation discount, annual meeting registration discount, etc.) _____

1. What is your campus location (select one)?

- Urban > 1,000,000 Suburban
 Urban 100,000 – 1,000,000 Rural
 Urban < 100,000 Other

3. As a condition of enrollment, does your institution require ALL full-time students to have some form of health insurance coverage? (Answer NO if you have requirements for some, but not all, full-time students.)

- Yes No Don't know

2. Indicate institutional attributes (select all that apply):

- 2-year only Indian Tribally Controlled College or University
 4-year Alaska Native-serving Institution
 Public Institution Native Hawaiian-serving Institution
 Private Institution Faith-based Institution
 Postsecondary Minority Institution None listed here
 Historically Black College or University (HBCU) Don't know
 High Hispanic Enrollment
 Hispanic-serving Institution (HSI)

4. To which entity does your student health service report (select one)?

- Academic Affairs or similar
 Business Affairs or similar
 Medical School/Hospital or similar
 Student Affairs or similar
 Other (specify): _____

II. FEES /FUNDING/DUES

5a. Indicate where the following programs/services are offered on your campus (select one for each service/program):

	Administratively Part of Health Services	Separate Entity	Not Offered
Medical and nursing services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Counseling/psychological services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health promotion/health education/wellness services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Student health insurance programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Services for students with disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pharmacy services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5b. Indicate which programs/services fall under your student health services budget (select all that apply):

	Yes	No	Not Offered
Medical and nursing services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Counseling/psychological services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health promotion/health education/wellness services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Student health insurance programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Services for students with disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pharmacy services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Please indicate the sources of revenue for the following programs/services (select all that apply):

	Health Fee	Student User/ Visit Fee	Health Insurance Reimbursement	General Revenue (e.g., public funding)	Tuition	Grants/ Endowments	Other
Medical and nursing services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Counseling/psychological services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health promotion/health education/wellness services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Student health insurance programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Services for students with disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreation services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Irrespective of other revenue sources, does the funding of the clinical health service include a designated "health fee" (separate from tuition and other institutional fees)? Yes No Don't know

8. Dues Calculation – This section is designed to help you calculate your institutional membership dues and should be completed by your institution's financial representative. *Do not include those expenses that do not directly relate to students, such as occupational health/mandatory student health insurance premiums. Note: The maximum institutional dues are \$2000.*

A. Base dues (paid by all institutions)	A.	\$ <u>375.00</u>		
B. Total Operating Budget (including salaries and benefits) \$ _____ X .00090 = <small>(Total Operating Budget)</small>	B.	\$ _____		
C. Enter the sum of Line A and Line B	C.	\$ _____		
D. Enter total from Box C or \$2000, whichever is less	D.			\$ _____
E. Application fee	E.			\$ 25.00
Enter the sum of lines D and E (Please remit completed form with payment)	Total due to ACHA:			\$ _____

III. PAYMENT METHOD

Check Enclosed (payable to ACHA) Purchase Order No. _____ Charge my: American Express Visa MasterCard

Card Number _____ Exp. Date _____ Card Security Code _____

Cardholder's Name _____ Billing Zip Code _____

Signature _____ Billing Contact _____ Phone # _____

Credit card payment receipts will be emailed to the Representative of the Member Institution (see "Representative Information" on page 3).

IV. REPRESENTATIVE INFORMATION

9. Representative of the Member Institution (RMI) – Complete the following information.

Prefix _____ First Name _____ Last Name _____ Middle Initial _____
Title _____ Professional Designation/Credential (s) _____
Email _____
Home phone _____ Cell _____
Work phone _____ Fax _____

10. Review preferences carefully:

Check here to be excluded (opt-out) from **mailing label** runs requested by outside companies/groups.

ACHA and its affiliates and sections use member email addresses solely for the purpose of communicating association business or college health related news to its members. Your email address will **never** be furnished to outside organizations/companies.

As a new member, you will receive **online subscriptions** to both the [Journal of American College Health](#) and the [College Health in Action Newsletter](#) as well as access to archives of past issues. To receive the mailed hard copy versions, please log in to your online account and update your preferences once you receive your welcome email.

11. Please complete the following information (select all that apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> Administrator | <input type="checkbox"/> Medical Records Specialist | <input type="checkbox"/> Physician Assistant |
| <input type="checkbox"/> Computer Specialist | <input type="checkbox"/> Nurse | <input type="checkbox"/> Physician (specialty _____) |
| <input type="checkbox"/> Dietitian/Nutritionist | <input type="checkbox"/> Nurse Director | <input type="checkbox"/> Psychiatrist |
| <input type="checkbox"/> Faculty | <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Psychologist or Counselor |
| <input type="checkbox"/> Health Educator | <input type="checkbox"/> Pharmacist | <input type="checkbox"/> Social Worker |
| | | <input type="checkbox"/> Other _____ |

12. ACHA has a policy of nondiscrimination and encourages diversity in its organization. Furnishing the following information is optional and is used only by ACHA for statistical purposes.

- | <u>Ethnicity</u> | <u>Gender</u> | <u>Age</u> |
|---|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> White (non Hispanic) | <input type="checkbox"/> Female | <input type="checkbox"/> 25 and under |
| <input type="checkbox"/> Asian/Pacific Islander | <input type="checkbox"/> Male | <input type="checkbox"/> 26 - 40 |
| <input type="checkbox"/> African American | <input type="checkbox"/> Transgender | <input type="checkbox"/> 41 - 64 |
| <input type="checkbox"/> Native American | | <input type="checkbox"/> 65 and over |
| <input type="checkbox"/> Hispanic/Latino | | |
| <input type="checkbox"/> Other _____ | | |

13. Select a [section affiliation](#): The designated RMI is granted a FREE ACHA individual membership and therefore may select one section (check one). Members have access to the web pages of all sections.

- | | | | |
|---|--|---|-----------------------------------|
| <input type="checkbox"/> Administration | <input type="checkbox"/> Clinical Medicine | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Nursing |
| <input type="checkbox"/> Advanced Practice Clinicians | <input type="checkbox"/> Health Promotion | <input type="checkbox"/> Nurse-Directed Health Services | <input type="checkbox"/> Pharmacy |

14. Select all [coalitions](#) that you would like to be actively involved in.

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Alcohol, Tobacco, and Other Drugs Coalition | <input type="checkbox"/> Ethnic Diversity Coalition | <input type="checkbox"/> Healthy Campus Coalition | <input type="checkbox"/> Spirituality, Religion, and Student Health Coalition |
| <input type="checkbox"/> Campus Safety and Violence Coalition | <input type="checkbox"/> Faculty and Staff Health and Wellness Coalition | <input type="checkbox"/> LGBTQ+ Health Coalition | <input type="checkbox"/> Student Health Insurance/ Benefits Plans Coalition |
| <input type="checkbox"/> Emerging Public Health Threats and Emergency Response Coalition | <input type="checkbox"/> Health Information Management Coalition | <input type="checkbox"/> Sexual Health Education and Clinical Care Coalition | <input type="checkbox"/> Travel Health Coalition |
| | | | <input type="checkbox"/> Wellness Needs of Military Veteran Students Coalition |

Continue to page 4 to enter Student Representative information

V. STUDENT REPRESENTATIVE INFORMATION

15. Designate a Student Representative of the Member Institution (SRMI) † - To facilitate communication among students and strengthen students'/ consumers' participation in the association, each institution is encouraged to name an SRMI. This designation is open to bona fide *students* at an institution of higher education; such *students* being those who are truly enrolled in a degree granting curriculum of course work and otherwise not gainfully employed or compensated to any substantial degree that would reasonably negate the expectation of discounted dues or fees. To be considered a full time student, you must be enrolled in a Graduate program taking a minimum of 9 semester hours or an Undergraduate program taking a minimum of 12 semester hours. The SRMI is granted a FREE membership in the Students/Consumers Section.

†Please note: Proof of student status, either an unofficial transcript or enrollment verification of status, must be sent along with the application and dues payment.

First Name _____ Last Name _____ Middle Initial _____

Major/degree program _____

Preferred Mailing Address (indicate if your preferred mailing address is your Home or School)

City _____ State _____ Zip _____ Country (if not USA) _____

Email _____ Cell Phone _____

Work phone _____ Fax _____

16. Review preferences carefully:

Check here to be excluded (opt-out) from **mailing label** runs requested by outside companies/groups.

ACHA and its affiliates and sections use member email addresses solely for the purpose of communicating association business or college health related news to its members. Your email address will **never** be furnished to outside organizations/companies.

As a new member, you will receive **online subscriptions** to both the [Journal of American College Health](#) and the [College Health in Action Newsletter](#) as well as access to archives of past issues.

17. Indicate area(s) of interest (select all that apply):

- Administration Clinical Medicine Mental Health Nursing
 Advanced Practice Clinicians Health Promotion Nurse-Directed Health Services Pharmacy

18. To be considered a full time student, you must be enrolled in a Graduate program taking a minimum of 9 semester hours or an Undergraduate program taking a minimum of 12 semester hours. Proof of student status, either an unofficial transcript or enrollment verification of status, must be sent along with the application. Are you: Graduate Undergraduate (response required)

How many semester hours are you currently enrolled in? _____

19. Are you: Unemployed Self-employed/consultant Employed? (response required)

Place of Employment _____

20. If employed or self-employed/consultant, number of hours involved in compensated activities per week: _____ (response required)

Compensated position/activity is for:

- 12 months per year 9 months per year 6 months per year 3 months per year Other _____

Please note that Student Members are not eligible for continuing education credits when attending the ACHA Annual Meeting.

Final Checklist Before Sending your Application to ACHA:

Did you make sure to?

- Calculate your total dues and add application fee
- Include your payment
- Include a copy of this completed application
- Include proof of student status if selecting a student member representative