ACHA American College Health Association

advocacy • education • research

Individual Membership Application for New Members

For the membership year January 1, 2019 through December 31, 2019

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. CONTACT INFORMATION

Prefix _____ First Name _____ Last Name _____ Middle Initial _____

Title _____ Professional Designation/Credential (s) _____

Institution Name _____

Preferred Mailing Address (Indicate if your preferred mailing address is your ☐ home or ☐ business)

_____

_____

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

Business Phone: _____ Fax: _____

☐Home or ☐Mobile Phone: _____ Email: _____

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

_____

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

1. 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, an additional fee will apply.

II. GENERAL INFORMATION

2. Indicate your area of practice/work (select all that apply):

☐ Administrator
☐ Computer Specialist
☐ Dietitian/Nutritionist
☐ Faculty
☐ Health Educator
☐ Medical Records Specialist
☐ Nurse
☐ Nurse Director
☐ Nurse Practitioner
☐ Pharmacist
☐ Physician Assistant
☐ Physician (specialty _____)
☐ Psychiatrist
☐ Psychologist or Counselor
☐ Social Worker
☐ Other _____

3. 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.

Ethnicity

☐ White (non-Hispanic)
☐ Asian/Pacific Islander
☐ African American
☐ Native American
☐ Hispanic/Latino
☐ Other_____

Birthday

Month _____

Year _____

III. MEMBERSHIP CATEGORY

4. Select your membership category.

Regular

☐ At a **Member Institution - $165**
(Your institution's member ID# _____)

☐ At a **Nonmember Institution - $195**

This category is open to anyone (a) providing health services to students at an institution of higher education, or (b) on the staff of an institution of higher education.

☐ $50 – add this amount to your total from above to receive mailed hard copies of the *Journal of American College Health* subscription.

Emeritus

☐ $35

☐ $85 – total with a *Journal of American College Health* mailed hard copy subscription

This category is open to any individual member in good standing at the time of retirement providing the member has held such individual membership status for at least five years immediately preceding retirement. Retirement shall mean that an individual member has withdrawn from active working life and is thus no longer employed to a significant degree, as determined by the Board of Directors, in college health or elsewhere. A letter of request for emeritus status approval, addressed to the ACHA CEO, must accompany this form if you have not previously held emeritus membership.

5. Select a primary section affiliation. Each ACHA individual member must select one primary section affiliation and as many others as preferred.

Primary section: (**choose one - required**)

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

Secondary section(s):

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

6. Select all coalitions that you would like to be actively involved in.

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

IV. DUES

Membership in ACHA is based on the calendar year. You will pay full annual dues, and your membership will be current January-December.

7. Enter the amount from the membership category & any additions selected above. **Total due to ACHA:** $_____

V. 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 ACHA Individual Member.