

Individual Membership Application for New Members

For the membership year January 1, 2018 through December 31, 2018

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):

- | | | |
|---|---|--|
| <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 _____ |

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

Birthday

- White (non-Hispanic)
 Asian/Pacific Islander
 African American
 Native American
 Hispanic/Latino
 Other _____

Month _____

Year _____

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)

- | | | | |
|---|--|---|-----------------------------------|
| <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 |

Secondary section(s):

- | | | | |
|---|--|---|-----------------------------------|
| <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 |

6. 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 |

III. MEMBERSHIP CATEGORY & DUES

4. Select your membership category. See section a. for dates on prorated and regular rates.

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.

- \$25 – add this amount to your total from above to receive mailed hard copies of the *Journal of American College Health* subscription. \$18.75 during proration

Emeritus

- \$35
- \$60 – 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 Executive Director, must accompany this form if you have not previously held emeritus membership.

Note: Membership in ACHA is based on the calendar year and your membership will be current through December 31, 2018. Use the proration schedule below to find your dues amount.

a. If you are **applying during the period of July 1 through December 31, 2018**, your dues will be prorated and current through December 31, 2018.

- | | |
|---|--|
| <input type="checkbox"/> Regular Member at a Member Institution - \$123.75 | <input type="checkbox"/> Emeritus Member - \$26.25 |
| <input type="checkbox"/> Regular Member at a Nonmember Institution - \$146.25 | <input type="checkbox"/> Emeritus Member w/ Journal subscription - \$26.25 + \$18.75 = \$45 |

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

IV. 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.