ACHA American College Health Association

advocacy • education • research

Institutional 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. GENERAL INFORMATION

Institution Name _____

Institution Mailing Address _____

_____

_____

_____

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

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

_____

_____

I. FEES/FUNDING/DUES

1. **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

2. **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.	$ 375.00		
B. Total Operating Budget (including salaries and benefits) $_____ (Total Operating Budget) X .00090 =	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. Mailed hard copy of Journal of American College Health - ***optional*** *(online subscription automatically included with membership)*	E.	$ 25.00		$_____
Enter the sum of lines D and E **(Please remit completed form with payment)**			**Total due to ACHA:**	$_____

II. 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 2).

III. REPRESENTATIVE INFORMATION

3. 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 _____

4. 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.

5. Please complete the following information (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 _____

6. 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_____

Gender
☐ Female
☐ Male
☐ Transgender

Birthday
Month _____
Year _____

7. 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

8. 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

Continue to page 3 to enter Student Representative information

IV. STUDENT REPRESENTATIVE INFORMATION

9. 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. A student will not be employed as a *professional* or *civil service* employee as determined by the Board of Directors. 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 _____

10. Review preferences carefully:

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

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11. 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

12. 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? _____

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

Place of Employment _____

14. 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?

- ☐ **Ensure info above reflects full-time student status and not employed full-time**
- ☐ **Calculate your total dues and include payment**
- ☐ **Include a copy of this completed application**

If assigning student rep:

- ☐ **Include proof of student status in the form of a transcript or enrollment verification**
- ☐ **Complete all questions in section 12-14**