

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 \$2,000.**

A. Base dues (paid by all institutions)	A.	\$ <u>375.00</u>		
B. Total Operating Budget (including salaries and benefits): \$ _____ X .00090 = <small>Health & Wellness Services/Student Health Center Budget</small> <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. Mailed hard copy of Journal of American College Health - <i>optional</i> (online subscription automatically included with membership) \$18.75 if prorated	E.	\$ 25.00 \$ 18.75 if prorated		\$ _____
F. STOP. Read below to see if your dues can be prorated. If the proration does not apply to you, enter the amount from box E in box F. If you are joining between the period of July 1 through Dec 31, 2018, your dues will be prorated and your membership will be current through December 31, 2018. Multiply (\$ _____ X .75 = \$ _____) Enter this result in box F. <small>Amount from box D</small>	F.			\$ _____
Enter the sum of lines E and F (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):

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

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.

<p><u>Ethnicity</u></p> <input type="checkbox"/> White (non-Hispanic) <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> African American <input type="checkbox"/> Native American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Other _____	<p><u>Birthday</u></p> <p>Month _____</p> <p>Year _____</p>
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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)

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

8. 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 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**