# APPLICATION FOR INSTITUTIONAL MEMBERSHIP IN KENTUCKY HOSPITAL ASSOCIATION

This institution hereby submits the necessary data and applies for Institutional Membership in the Kentucky Hospital Association.

**PLEASE PRINT OR TYPE**

Name of Institution _____

Mailing Address _____ Telephone (  ) _____

City_____ State _____ Zip Code_____

Year Established _____ Fiscal Year Ends_____

Name of Chief Executive Officer _____

Chief Executive Officer Title_____

Is hospital owned, leased or managed?_____

Ownership: __ Government __ Investor-Owned __ Non-Government

Number of beds:_____

Number of employees _____

Signed _____

**Please complete and return to:**

Kentucky Hospital Association
P.O. Box 436629
Louisville, Kentucky 40253-6629

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**KHA USE ONLY**

Date Presented to Board of Trustees: _____

( ) Membership Certificate
( ) Type I-A ( ) Type II-A
( ) Type I-B ( ) Type II-B
( ) Mailing List

Action by Board of Trustees: _____

**KENTUCKY HOSPITAL ASSOCIATION**
**APPLICATION FORM**
**TYPE III INSTITUTIONAL MEMBERSHIP**

I hereby make application for Type III Institutional Membership in the Kentucky Hospital Association and submit the following data for consideration.

**PLEASE PRINT OR TYPE**

Institution _____

Mailing Address _____ Telephone (  ) _____

City_____ State _____ Zip Code_____

Name of Chief Executive Officer _____

Title _____

Signature _____

Date _____

**Please submit application in duplicate.** Remittance of $500.00 for annual dues should accompany this application. Make check payable to *Kentucky Hospital Association.*

**Please complete and return to:**

Kentucky Hospital Association
P.O. Box 436629
Louisville, Kentucky 40253-6629

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**KHA USE ONLY**

Date Received _____

Date Approved by the Board of Trustees_____

Dues Received_____

**KENTUCKY HOSPITAL ASSOCIATION**
**APPLICATION FORM**
**TYPE IV INSTITUTIONAL MEMBERSHIP**

I hereby make application for Type IV Institutional Membership in the Kentucky Hospital Association and submit the following data for consideration.

**PLEASE TYPE OR PRINT**

Institution/Organization _____

Mailing Address _____ Telephone (  ) _____

City _____ State _____ Zip Code _____

Name of Chief Executive Officer _____

Title _____

Nature of Business _____

Signature _____

Date _____

**Please submit application in duplicate.** Remittance of $500.00 for annual dues should accompany this application. Make check payable to *Kentucky Hospital Association.*

**Please complete and return to:**

Kentucky Hospital Association
P.O. Box 436629
Louisville, Kentucky 40253-6629

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**KHA USE ONLY**

Date Received _____

Date Approved by the Board of Trustees _____

Dues Received _____

**KENTUCKY HOSPITAL ASSOCIATION**
**APPLICATION FORM**
**TYPE VI INSTITUTIONAL MEMBERSHIP**

I hereby make application for Type VI Membership in the Kentucky Hospital Association and submit the following data for consideration:

**PLEASE TYPE OR PRINT**

Institution/Organization _____

Mailing Address _____ Telephone ( ) _____

City_____ State _____ Zip Code_____

Name of Chief Executive Officer _____

Title _____

Nature of Business_____

Signature _____

Date _____

**Please submit application in duplicate.** Remittance of $250.00 for annual dues should accompany this application. Make check payable to *Kentucky Hospital Association.*

**Please complete and return to:**

Kentucky Hospital Association
P.O. Box 436629
Louisville, Kentucky 40253-6629

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**KHA USE ONLY**

Date Received _____

Date Approved by the Board of Trustees_____

Dues Received_____

**APPLICATION FOR PERSONAL MEMBERSHIP IN KENTUCKY HOSPITAL ASSOCIATION**

I hereby make application for Personal Membership in the Kentucky Hospital Association and submit the following data for consideration:

**PLEASE TYPE OR PRINT**

Name of Individual _____

Institution/Organization _____

Mailing Address _____ Telephone (  ) _____

City_____ State _____ Zip Code_____

Of what other hospital or professional organization are you a member?

_____

Signature _____

Date _____

**Please submit application in duplicate.** Remittance of $60.00 for annual dues should accompany this application. Make check payable to *Kentucky Hospital Association.*

**Please complete and return to:**

Kentucky Hospital Association
P.O. Box 436629
Louisville, Kentucky 40253-6629

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**KHA USE ONLY**

Date Received _____

Date Approved by the Board of Trustees_____

Dues Received_____