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		Tele	phone ()
City	State		Zip Coo	le
Year Established		Fiscal Yea	ar Ends_	
Name of Chief Executiv	e Officer			
Chief Executive Officer	Title			
Is hospital owned, lease	ed or managed	J?		
Ownership: G	overnment _	_Investor-Own	ed No	n-Government
Number of beds:				
Number of employees _				
	Sigr	ned		
	Please comp	lete and retur	n to:	
	P.O. E	ospital Associat Box 436629 ntucky 40253-6		
		USE ONLY		
Date Presented to Board	d of Trustees:			
			() Type	bership Certificate I-A () Type II-A I-B () Type II-B ig List
Action by Board of Trust	eec.			

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 ()
CityState	Zip Code
Name of Chief Executive Officer	
Title	
	Signature
	Date
Please submit application in dudues should accompany this applemental Association.	Iplicate. Remittance of \$500.00 for annual lication. Make check payable to <i>Kentucky</i>
Please c	omplete and return to:
P Louisville	ky Hospital Association P.O. Box 436629 e, Kentucky 40253-6629
	HA USE ONLY
Date Received	
Date Approved by the Board of Ti	rustees
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/Organizati	on				
Mailing Address		Telephone()			
City	State	Zip Code			
Name of Chief Execu	itive Officer				
Title					
Nature of Business					
	Signa	ature			
Date					
	_	te. Remittance of \$500.00 for annual n. Make check payable to <i>Kentucky</i>			
	Please comple	te and return to:			
	P.O. Bo	pital Association x 436629 ucky 40253-6629			
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	KHA US	SE ONLY			
Date Received					
Date Approved by the E	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:					
P	y Hospital Association .O. Box 436629 , Kentucky 40253-6629				
	HA USE ONLY				
Date Received					
Date Approved by the Board of Tr	ustees				
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/Organiza	tion	<del>- 44 </del>		
Mailing Address		Telephone ( )		
City	State	Zip Code		
Of what other hospit	tal or professional	organization are you a member?		
	Sign	ature		
	Date			
Please submit appl should accompany the Association.	ication in duplica	ate. Remittance of \$60.00 for annual dues ake check payable to <i>Kentucky Hospital</i>		
	Please compl	ete and return to:		
		spital Association		
P.O. Box 436629 Louisville, Kentucky 40253-6629				
		SE ONLY		
Date Received				
Date Approved by the	Board of Trustee	s		
Dues Received				