



Individual Membership Application for New Members

For the membership year January 1, 2012 through December 31, 2012

COMPLETE THIS FORM IN ITS ENTIRETY AND RETURN IT WITH YOUR DUES PAYMENT TO: Membership Coordinator, American College Health Association, 1362 Mellon Road, Suite 180, Hanover, MD 21076, or fax to (410) 859-1510, or email to membership@acha.org. Contact ACHA at (410) 859-1500 or membership@acha.org if you have questions.

I. CONTACT INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Title _____ Degree (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 _____ Home Phone _____

Email _____ Fax _____

1. Review exclusion options 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. By opting out, you will no longer receive important email communications or updates from the association, your affiliate, or your section. Your email address will **never** be furnished to outside organizations/companies.

Check here to be excluded (opt-out) from ACHA broadcast emails.

II. GENERAL INFORMATION

2. Indicate institutional attributes (select all that apply):

- | | | |
|--|---|--|
| <input type="checkbox"/> 2-year only | <input type="checkbox"/> High Hispanic Enrollment | <input type="checkbox"/> Native Hawaiian-serving Institution |
| <input type="checkbox"/> 4-year | <input type="checkbox"/> Hispanic-serving Institution (HSI) | <input type="checkbox"/> Faith-based Institution |
| <input type="checkbox"/> Public Institution | <input type="checkbox"/> Indian Tribally Controlled College or University | <input type="checkbox"/> None listed here |
| <input type="checkbox"/> Private Institution | <input type="checkbox"/> Alaska Native-serving Institution | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> Postsecondary Minority Institution | | |
| <input type="checkbox"/> Historically Black College or University (HBCU) | | |

3. Indicate your area of practice/work (select all that apply):

- | | | |
|---|--|--|
| <input type="checkbox"/> Administrator | <input type="checkbox"/> Nurse | <input type="checkbox"/> Physician (specialty _____) |
| <input type="checkbox"/> Computer Specialist | <input type="checkbox"/> Nurse Director | <input type="checkbox"/> Psychologist or Counselor |
| <input type="checkbox"/> Dietitian/Nutritionist | <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> Health Educator | <input type="checkbox"/> Pharmacist | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Medical Records Specialist | <input type="checkbox"/> Physician Assistant | |

4. 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.

- | | | |
|---|--------------------------------------|---------------------------------------|
| <u>Ethnicity</u> | <u>Gender</u> | <u>Age</u> |
| <input type="checkbox"/> White (non Hispanic) | <input type="checkbox"/> Female | <input type="checkbox"/> 25 and under |
| <input type="checkbox"/> Asian/Pacific Islander | <input type="checkbox"/> Male | <input type="checkbox"/> 26-40 |
| <input type="checkbox"/> African American | <input type="checkbox"/> Transgender | <input type="checkbox"/> 41-64 |
| <input type="checkbox"/> Native American | | <input type="checkbox"/> 65 and over |
| <input type="checkbox"/> Hispanic/Latino | | |
| <input type="checkbox"/> Other _____ | | |

III. MEMBERSHIP CATEGORY

5. Select your desired membership category.

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. Includes *Journal of American College Health* subscription.

Associate

- \$195
- This category is open to anyone not eligible for regular membership. Benefits are the same as those for regular members except that associate members are not eligible to vote or hold office in either ACHA or its sections. Includes *Journal of American College Health* subscription.

Emeritus

- \$35
- \$85 – with a *Journal of American College Health* 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.

6. Select one section affiliation. Each ACHA individual member may select one section affiliation at no charge. Members have access to the web pages of all sections. **Visit www.acha.org for more details about sections.**

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

7. Select all coalitions you would like to join. Visit www.acha.org for more details about coalitions.

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Advocacy Coalition | <input type="checkbox"/> Coalition for the Wellness Needs of Military Veteran Students | <input type="checkbox"/> Faculty and Staff Health and Wellness Coalition | <input type="checkbox"/> Sexual Health Education and Clinical Care Coalition |
| <input type="checkbox"/> Alcohol, Tobacco, and Other Drugs Coalition | <input type="checkbox"/> Emerging Public Health Threats and Emergency Response Coalition | <input type="checkbox"/> HIPAA/HIM Coalition | <input type="checkbox"/> Spirituality, Religion, and Student Health Coalition |
| <input type="checkbox"/> Allies for LGBT Health Coalition | <input type="checkbox"/> Ethnic Diversity Coalition | <input type="checkbox"/> National Health Objectives for 2020 Coalition | <input type="checkbox"/> Student Health Insurance/Benefits Plans Coalition |
| <input type="checkbox"/> Campus Safety and Violence Coalition | | | |

IV. DUES

Note: Membership in ACHA is based on the calendar year. You will pay full annual dues, and your membership will be current through December 31 of this year with the following exception. If you are applying during the period of October 1 through December 31, you will pay full annual dues but will receive the remainder of this year free, and your membership will be current through December 31 of next year.

8. Enter the amount from the membership category selected above.

	\$ _____
One-time application fee	\$ 15.00
Total due to ACHA:	\$ _____

V. 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 _____ Signature _____

Billing Contact _____ Phone # _____

Credit card payment receipts will be emailed to the ACHA Individual Member.