



Institutional 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. GENERAL INFORMATION

Institution Name _____

Institution Mailing Address _____

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

1. What is your campus location (select one)?

- Urban > 1,000,000
- Urban 100,000 – 1,000,000
- Urban < 100,000
- Suburban
- Rural
- Other

3. As a condition of enrollment, does your institution require ALL full-time students to have some form of health insurance coverage? (Answer NO if you have requirements for some, but not all, fulltime students.)

- Yes
- No
- Don't know

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

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

4. To which entity does your student health service report (select one)?

- Academic Affairs or similar
- Business Affairs or similar
- Medical School/Hospital or similar
- Student Affairs or similar
- Other (specify): _____

II. FEES /FUNDING/DUES

5a. Indicate where the following programs/services are offered on your campus (select one for each service/program):

	Administratively Part of Health Services	Separate Entity	Not offered
Medical and nursing services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Counseling/psychological services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health promotion/health education/wellness services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Student health insurance programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Services for students with disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pharmacy services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5b. Indicate which programs/services fall under your student health services budget (select all that apply):

	Yes	No	Not Offered
Medical and nursing services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Counseling/psychological services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health promotion/health education/wellness services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Student health insurance programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Services for students with disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pharmacy services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Please indicate the sources of revenue for the following programs/services (select all that apply):							
	Health Fee	Student User/ Visit Fee	Health Insurance Reimbursement	General Revenue (e.g. public funding)	Tuition	Grants/ Endowments	Other
Medical and nursing services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Counseling/psychological services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health promotion/health education/wellness services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Student health insurance programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Services for students with disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreation services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. 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

8. **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)	B.	\$ _____		
C. Multiply total operating budget by .00090. (\$ _____ X .00090 = \$ _____)	C.	\$ _____		
D. Enter the sum of Line A and Line C	D.		\$ _____	
E. Enter total from Box D or \$2000 whichever is less	E.			\$ _____
F. One-time application fee	F.			\$ 25.00
Enter the sum of lines E and F	Total due to ACHA:			\$ _____

III. 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 Representative of the Member Institution (see "Representative Information" on page 3).

IV. REPRESENTATIVE INFORMATION

9. Representative of the Member Institution (RMI) – Complete the following information.

Last Name _____ First Name _____ Middle Initial _____
Title _____ Degree (s) _____
Email _____
Home phone _____ Cell _____
Work phone _____ Fax _____

10. 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.

11. Please complete the following information (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 | |

12. 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 _____ | | |

13. Select a section affiliation: The designated RMI is granted a FREE ACHA individual membership and therefore may select one section (check one). 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 |

14. 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 | | | |

Continue to page 4 to enter Student Representative information

V. STUDENT REPRESENTATIVE INFORMATION

15. 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. The SRMI is granted a FREE membership in the Students/Consumers Section.

†Please note: Proof of student status must be sent along with the application and dues payment. An unofficial transcript or enrollment verification of status must be sent with the application.

Last Name _____ First Name _____ Middle Initial _____

Major/degree program _____

Email _____ Cell Phone _____

Work phone _____ Fax _____

16. 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.

17. Indicate area(s) of interest (select all that apply):

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

18. Are you: Unemployed Self-employed/consultant Employed?

Place of Employment _____

19. If employed or self-employed/consultant, number of hours involved in compensated activities per month: _____