



Student 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 AND PROOF OF STUDENT STATUS 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 _____

Institution Name _____

Major/degree program _____

Preferred Mailing Address _____

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

Email _____ Cell Phone _____

Work Phone _____ 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. 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 _____ | | | |

4. 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 |

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

Place of Employment _____

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

III. MEMBERSHIP CATEGORY

7. Select from the student membership options below.

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. **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.**

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

IV. DUES

8. Enter the amount from the membership category option 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 Student Member.