



AMERICAN  
COLLEGE  
HEALTH  
ASSOCIATION

## Institutional Membership Application for New Members

For the membership year January 1, 2020 through December 31, 2020

**EMAIL COMPLETED FORM TO:** [membership@acha.org](mailto:membership@acha.org) OR fax to (410) 859-1510 OR mail with check payment to American College Health Association, P. O. Box 419224 Boston, MA 02241-9224. Contact ACHA at (410) 859-1500 or [membership@acha.org](mailto:membership@acha.org) for questions.

### I. GENERAL INFORMATION

Institution Name \_\_\_\_\_  
 Institution Mailing Address \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Country (if not USA) \_\_\_\_\_

Reason(s) for joining ACHA (e.g., NCHA survey participation discount, annual meeting registration discount, etc.) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### I. FEES/FUNDING/DUES

**1. 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 \$2,000.*

A. Base dues (paid by all institutions)	A.	\$ <u>375.00</u>									
B. Total Operating Budget (including salaries and benefits): \$ _____ X .00090 = <small>Health &amp; Wellness Services/Student Health Center Budget</small> <span style="float:right"><small>Total Operating Budget</small></span>	B.	\$ _____									
C. Enter the sum of Line A and Line B	C.	\$ _____									
D. Enter total from Box C or \$2000, whichever is less	D.		\$ _____								
E. <b>STOP.</b> Read below to see if your dues can be prorated. If the proration does not apply to you, enter the amount from box D in the <i>total due to ACHA</i> line.  <b>If you are joining between the period of July 1 through Sep 30, 2020, your dues will be prorated, and your membership will be current through December 31, 2020.</b>	E.		\$ _____								
<table border="1"> <thead> <tr> <th>MONTH</th> <th>Prorated Calculation</th> </tr> </thead> <tbody> <tr> <td><b>July/August</b></td> <td> <ul style="list-style-type: none"> <li>• Multiply amount from box D (\$ _____ X .50 = \$ _____) Enter this result in box E.</li> <li>• (optional) Journal of American College Health, mailed hard copy = <b>\$12.50</b></li> </ul> </td> </tr> <tr> <td><b>September</b></td> <td> <ul style="list-style-type: none"> <li>• Multiply amount from box D (\$ _____ X .25 = \$ _____) Enter this result in box E.</li> <li>• (optional) Journal of American College Health, mailed hard copy = <b>\$6.25</b></li> </ul> </td> </tr> <tr> <td><b>October - December</b></td> <td>If you wait until October 1<sup>st</sup>, we will begin processing 2021 memberships at the full membership rate again and you'll receive those 3 months free plus the full 2021 calendar year. Your membership will be active from October 1<sup>st</sup>, 2020 – December 31<sup>st</sup>, 2021. Those applications will be available on our website starting October 1<sup>st</sup>.</td> </tr> </tbody> </table>	MONTH	Prorated Calculation	<b>July/August</b>	<ul style="list-style-type: none"> <li>• Multiply amount from box D (\$ _____ X .50 = \$ _____) Enter this result in box E.</li> <li>• (optional) Journal of American College Health, mailed hard copy = <b>\$12.50</b></li> </ul>	<b>September</b>	<ul style="list-style-type: none"> <li>• Multiply amount from box D (\$ _____ X .25 = \$ _____) Enter this result in box E.</li> <li>• (optional) Journal of American College Health, mailed hard copy = <b>\$6.25</b></li> </ul>	<b>October - December</b>	If you wait until October 1 <sup>st</sup> , we will begin processing 2021 memberships at the full membership rate again and you'll receive those 3 months free plus the full 2021 calendar year. Your membership will be active from October 1 <sup>st</sup> , 2020 – December 31 <sup>st</sup> , 2021. Those applications will be available on our website starting October 1 <sup>st</sup> .			
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F. Mailed hard copy of Journal of American College Health - <b>optional</b> <i>(online subscription automatically included with membership)</i>	F.	\$ 25.00	\$ _____								
Enter the sum of lines E and F (Please remit completed form with payment)	<b>Total due to ACHA:</b>		\$ _____								

**II. 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 \_\_\_\_\_ Billing Zip Code \_\_\_\_\_

Signature \_\_\_\_\_ Billing Contact \_\_\_\_\_ Phone # \_\_\_\_\_

***Credit card payment receipts will be emailed to the Representative of the Member Institution (see "Representative Information" on page 3).***

**ACHA memberships are final and non-refundable.**

### III. REPRESENTATIVE INFORMATION

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

Prefix \_\_\_\_\_ First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Title \_\_\_\_\_ Professional Designation/Credential (s) \_\_\_\_\_

Email \_\_\_\_\_

Home phone \_\_\_\_\_ Cell \_\_\_\_\_

Work phone \_\_\_\_\_ Fax \_\_\_\_\_

**4. Review preferences 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.** Your email address will **never** be furnished to outside organizations/companies.

As a new member, you will receive **online subscriptions** to both the [Journal of American College Health](#) and the [College Health in Action Newsletter](#) as well as access to archives of past issues. To receive the mailed hard copy versions, an additional fee will apply.

**5. Please complete the following information (select all that apply):**

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

**6. 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.

Ethnicity

- |   |   |
|---|---|
| <input type="checkbox"/> African American       | <input type="checkbox"/> Native American      |
| <input type="checkbox"/> Asian/Pacific Islander | <input type="checkbox"/> White (non-Hispanic) |
| <input type="checkbox"/> Hispanic/Latino        | <input type="checkbox"/> Other _____          |

Birthdate

Month \_\_\_\_\_

Year \_\_\_\_\_

**7. Select a primary [section affiliation](#).** Each ACHA individual member must select one primary section affiliation and as many others as preferred.

**Primary section: (choose one - required)**

- |   |  |   |                                   |
|---|--|---|-----------------------------------|
| <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 Administrators | <input type="checkbox"/> Pharmacy |

**Secondary section(s):**

- |   |  |   |                                   |
|---|--|---|-----------------------------------|
| <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 Administrators | <input type="checkbox"/> Pharmacy |

**8. Select all [coalitions](#) that you would like to be actively involved in.**

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Alcohol, Tobacco, and Other Drugs Coalition                     | <input type="checkbox"/> Ethnic Diversity Coalition                      | <input type="checkbox"/> Historically Black Colleges & Universities (HBCU) Coalition | <input type="checkbox"/> Sports Medicine Coalition                             |
| <input type="checkbox"/> Campus Safety and Violence Coalition                            | <input type="checkbox"/> Faculty and Staff Health and Wellness Coalition | <input type="checkbox"/> LGBTQ+ Health Coalition                                     | <input type="checkbox"/> Student Health Insurance/ Benefits Plans Coalition    |
| <input type="checkbox"/> Emerging Public Health Threats and Emergency Response Coalition | <input type="checkbox"/> Health Information Management Coalition         | <input type="checkbox"/> Sexual Health Education and Clinical Care Coalition         | <input type="checkbox"/> Travel Health Coalition                               |
|  | <input type="checkbox"/> Healthy Campus Coalition                        | <input type="checkbox"/> Spirituality, Religion, and Student Health Coalition        | <input type="checkbox"/> Wellness Needs of Military Veteran Students Coalition |

**Continue to page 4 to enter Student Representative information**

#### IV. STUDENT REPRESENTATIVE INFORMATION

**9. 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. A student will not be employed as a *professional* or *civil service* employee as determined by the Board of Directors. To be considered a full time student, you must be enrolled in a Graduate program taking a minimum of 9 semester hours or an Undergraduate program taking a minimum of 12 semester hours. The SRMI is granted a FREE membership in the Students/Consumers Section.

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

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Major/degree program \_\_\_\_\_

Preferred Mailing Address (indicate if your preferred mailing address is your  Home or  School)

\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Country (if not USA) \_\_\_\_\_

Email \_\_\_\_\_ Cell Phone \_\_\_\_\_

Work phone \_\_\_\_\_ Fax \_\_\_\_\_

#### 10. Review preferences 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.** Your email address will **never** be furnished to outside organizations/companies.

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

- Administration  Clinical Medicine  Mental Health  Nursing  
 Advanced Practice Clinicians  Health Promotion  Nurse Administrators  Pharmacy

**12. To be considered a full time student, you must be enrolled in a Graduate program taking a minimum of 9 semester hours or an Undergraduate program taking a minimum of 12 semester hours. Proof of student status, either an unofficial transcript or enrollment verification of status, must be sent along with the application.** Are you:  Graduate  Undergraduate (**response required**)

How many semester hours are you currently enrolled in? \_\_\_\_\_

**13. Are you:**  Unemployed  Self-employed/consultant  Employed? (**response required**)

Place of Employment \_\_\_\_\_

**14. If employed or self-employed/consultant, number of hours involved in compensated activities per week:** \_\_\_\_\_ (**response required**)

**Compensated position/activity is for:**

12 months per year  9 months per year  6 months per year  3 months per year Other \_\_\_\_\_

Please note that Student Members are not eligible for continuing education credits when attending the ACHA Annual Meeting.

#### Final Checklist Before Sending your Application to ACHA:

Did you make sure to?

- Ensure info above reflects full-time student status and not employed full-time  
 Calculate your total dues and include payment  
 Include a copy of this completed application  
If assigning student rep:  
 Include proof of student status in the form of a transcript or enrollment verification  
 **Complete all questions in section 12-14**