



Institutional Membership Application for New Members

For the membership year January 1, 2021 through December 31, 2021

EMAIL COMPLETED FORM TO: 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 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. Simply identify your total health and well-being budget as defined by spending related to health services, counseling services, and/or health promotion services (includes any departmental expenditures, salaries, benefits, contracted services, staffing, equipment, supplies, overhead, etc.) and find the corresponding range below:

SELECTION	LEVEL	HEALTH & WELL-BEING BUDGET	TOTAL DUES
<input type="checkbox"/>	Level 1	No health or well-being program	\$430
<input type="checkbox"/>	Level 2	25k to 49k	\$470
<input type="checkbox"/>	Level 3	50k to 99k	\$530
<input type="checkbox"/>	Level 4	100k to 199k	\$650
<input type="checkbox"/>	Level 5	200k to 299k	\$760
<input type="checkbox"/>	Level 6	300k to 499k	\$880
<input type="checkbox"/>	Level 7	500k to 699k	\$1,100
<input type="checkbox"/>	Level 8	700k to 899k	\$1,300
<input type="checkbox"/>	Level 9	900k to 1.1M	\$1,800
<input type="checkbox"/>	Level 10	1.1M to 1.5M	\$2,100
<input type="checkbox"/>	Level 11	1.5M to 1.9M	\$2,600
<input type="checkbox"/>	Level 12	1.9M to 3M	\$3,000
<input type="checkbox"/>	Level 13	3M to 9.9M	\$3,500
<input type="checkbox"/>	Level 14	>10M	\$4,000

Mailed hard copy of Journal of American College Health - <i>optional</i> (online subscription for 3 members automatically included with membership)	E.	\$ 25.00	\$ _____
(Please remit completed form with payment if using a check)	Total due to ACHA:		\$ _____

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 # _____

Payment receipts will be emailed to the Representative noted on page 2. **ACHA memberships are final and non-refundable.**

III. REPRESENTATIVE INFORMATION

2. 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 _____

3. 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 the member rep, you will be able to select 3 members from your school to receive free **online subscription access** to the [Journal of American College Health](#). You will also receive online access to the [College Health in Action Newsletter](#) as well as access to archives of past issues.

4. 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 _____ |

5. 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

- African American
 Asian/Pacific Islander
 Hispanic/Latino
 Native American
 White (non-Hispanic)
 Other _____

Birthday

Month _____
 Year _____

6. Select a primary [section affiliation](#). Each ACHA individual member must select one primary section affiliation and as many others as preferred. You will receive email alerts, news, and updates from the selected section.

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 |

7. 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) | <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 |