Institutional Membership Application for New Members

For the membership year January 1, 2023, through December 31, 2023

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 ____________________

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City ____________ State ______ Zip ________ Country (if not USA) ____________

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

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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
☐	Level 1	No health or well-being program	$430
☐	Level 2	25k to 49k	$470
☐	Level 3	50k to 99k	$530
☐	Level 4	100k to 199k	$650
☐	Level 5	200k to 299k	$760
☐	Level 6	300k to 499k	$880
☐	Level 7	500k to 699k	$1,100
☐	Level 8	700k to 899k	$1,300
☐	Level 9	900k to 999k	$1,800
☐	Level 10	1M to 1.4M	$2,100
☐	Level 11	1.5M to 1.9M	$2,600
☐	Level 12	2M to 2.9M	$3,000
☐	Level 13	3M to 9.9M	$3,500
☐	Level 14	>10M	$4,000

Mailed hard copy of Journal of American College Health - ***optional*** *(online subscription for 3 members 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 non-refundable.**

III. REPRESENTATIVE INFORMATION

2. Representative of the Member Institution (RMI) – **Main contact for institution.**

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):

☐ Administrator
☐ Computer Specialist
☐ Dietitian/Nutritionist
☐ Faculty
☐ Health Educator
☐ Medical Records Specialist
☐ Nurse
☐ Nurse Director
☐ Nurse Practitioner
☐ Pharmacist
☐ Physician Assistant
☐ Physician (specialty ___________)
☐ Psychiatrist
☐ Psychologist or Counselor
☐ Social Worker
☐ 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 be eligible to vote in the ACHA election as well as receive email alerts, news, and updates from the selected section.

Primary section: (choose one - required)

☐ Administrator
☐ Advanced Practice Clinicians
☐ Clinical Medicine
☐ Health Promotion
☐ Mental Health
☐ Nurse Administrators
☐ Nursing
☐ Pharmacy

Secondary section(s): (optional)

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

7. Select all coalitions that you would like to be **actively involved** in.

☐ Alcohol, Tobacco, and Other Drugs Coalition
☐ Campus Safety and Violence Coalition
☐ Emerging Public Health Threats and Emergency Response Coalition
☐ Ethnic Diversity Coalition
☐ Faculty and Staff Health and Wellness Coalition
☐ Health Information Management Coalition
☐ Historically Black Colleges & Universities (HBCU)
☐ LGBTQ+ Health Coalition
☐ Racial Marginalization & Health Inequities Coalition
☐ Sexual Health Coalition
☐ Spirituality, Religion, and Student Health Coalition
☐ Sports Medicine Coalition
☐ Student Health Insurance/ Benefits Plans Coalition
☐ Travel Health Coalition
☐ Wellness Needs of Military Veteran Students Coalition