AMERICAN COLLEGE HEALTH ASSOCIATION

Institutional Membership Application for New Members

For the membership year January 1, 2024, through December 31, 2024

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.

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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How did you hear about ACHA? (e.g., ACHA promo postcard, colleague, social media, another association, 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 if appropriate. 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:

SELECTION	LEVEL	HEALTH & WELL-BEING BUDGET	TOTAL DUES
☐	Level 1	No health or well-being program	$450
☐	Level 2	$25,000 - $49,999	$490
☐	Level 3	$50,000 – $99,999	$550
☐	Level 4	$100,000 - $199,999	$680
☐	Level 5	$200,000 - $299,999	$800
☐	Level 6	$300,000 - $499,999	$920
☐	Level 7	$500,000 - $699,999	$1,150
☐	Level 8	$700,000 - $899,999	$1,360
☐	Level 9	$900,000 - $999,999	$1,900
☐	Level 10	$1M - $1.4M	$2,200
☐	Level 11	$1.5M - $1.9M	$2,700
☐	Level 12	$2M - $2.9M	$3,200
☐	Level 13	$3M - $9.9M	$3,750
☐	Level 14	Greater than $10M	$4,250

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)

☐ Administration
☐ 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
☐ Community College Health Coalition
☐ Emerging Public Health Threats and Emergency Response Coalition
☐ Faculty and Staff Health and Wellness Coalition
☐ Health Information Management Coalition
☐ Historically Black Colleges & Universities (HBCU)
☐ Integrated College Health Coalition
☐ LGBTQ+ Health Coalition
☐ Sexual Health Coalition
☐ Spirituality and Wellness Coalition
☐ Sports Medicine Coalition
☐ Student Health Insurance/ Benefits Plans Coalition
☐ Travel Health Coalition
☐ Wellness Needs of Military Veteran Students Coalition