ACHA American College Health Association

advocacy • education • research

Institutional Membership Application for New Members

For the membership year January 1, 2017 through December 31, 2017

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) _____

How did you hear about ACHA (e.g., colleague, internet, advertisement, etc.) _____

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

_____

_____

1. What is your campus location (select one)?

- ☐ Urban > 1,000,000
- ☐ Urban 100,000 – 1,000,000
- ☐ Urban < 100,000
- ☐ Suburban
- ☐ Rural
- ☐ Other

2. Indicate institutional attributes (select all that apply):

- ☐ 2-year only
- ☐ 4-year
- ☐ Public Institution
- ☐ Private Institution
- ☐ Postsecondary Minority Institution
- ☐ Historically Black College or University (HBCU)
- ☐ High Hispanic Enrollment
- ☐ Hispanic-serving Institution (HSI)
- ☐ Indian Tribally Controlled College or University
- ☐ Alaska Native-serving Institution
- ☐ Native Hawaiian-serving Institution
- ☐ Faith-based Institution
- ☐ None listed here
- ☐ Don't know

3. As a condition of enrollment, does your institution require ALL full-time students to have some form of health insurance coverage? (Answer NO if you have requirements for some, but not all, full-time students.)

☐ Yes ☐ No ☐ Don't know

4. To which entity does your student health service report (select one)?

- ☐ Academic Affairs or similar
- ☐ Business Affairs or similar
- ☐ Medical School/Hospital or similar
- ☐ Student Affairs or similar
- ☐ Other (specify):

_____

II. FEES /FUNDING/DUES

5a. Indicate where the following programs/services are offered on your campus (select one for each service/program):

	Administratively Part of Health Services	Separate Entity	Not Offered
Medical and nursing services	☐	☐	☐
Counseling/psychological services	☐	☐	☐
Health promotion/health education/wellness services	☐	☐	☐
Student health insurance programs	☐	☐	☐
Services for students with disabilities	☐	☐	☐
Pharmacy services	☐	☐	☐
Other (specify):	☐	☐	☐
Other (specify):	☐	☐	☐

5b. Indicate which programs/services fall under your student health services budget (select all that apply):

	Yes	No	Not Offered
Medical and nursing services	☐	☐	☐
Counseling/psychological services	☐	☐	☐
Health promotion/health education/wellness services	☐	☐	☐
Student health insurance programs	☐	☐	☐
Services for students with disabilities	☐	☐	☐
Pharmacy services	☐	☐	☐
Other (specify):	☐	☐	☐
Other (specify):	☐	☐	☐

6. Please indicate the sources of revenue for the following programs/services (select all that apply):

	Health Fee	Student User/ Visit Fee	Health Insurance Reimbursement	General Revenue (e.g. public funding)	Tuition	Grants/ Endowments	Other
Medical and nursing services	☐	☐	☐	☐	☐	☐	☐
Counseling/psychological services	☐	☐	☐	☐	☐	☐	☐
Health promotion/health education/wellness services	☐	☐	☐	☐	☐	☐	☐
Student health insurance programs	☐	☐	☐	☐	☐	☐	☐
Services for students with disabilities	☐	☐	☐	☐	☐	☐	☐
Recreation services	☐	☐	☐	☐	☐	☐	☐
Other (specify):	☐	☐	☐	☐	☐	☐	☐
Other (specify):	☐	☐	☐	☐	☐	☐	☐

7. Irrespective of other revenue sources, does the funding of the clinical health service include a designated "Health Fee" (separate from tuition and other institutional fees)? ☐ Yes ☐ No ☐ Don't know

8. 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 $2000.***

A. Base dues (paid by all institutions)	A.	$ 375.00		
B. Total Operating Budget (including salaries and benefits)	B.	$_____		
C. Multiply total operating budget by .00090. ($_____ X .00090 = $_____)	C.	$_____		
D. Enter the sum of Line A and Line C	D.		$_____	
E. Enter total from Box D *or* $2000 whichever is less	E.		$_____	
F. STOP. Read below to see if your dues can be prorated. If the proration does not apply to you, enter the amount form box E in box F. **If you are joining between the period of July 1 through December 31, 2017, your dues will be prorated and your membership will be current through December 31, 2017.** Multiply ($_____ (Amount from box E) X .75 = $_____) Enter this result in box F.	F.			$_____
G. Application fee	G.			$ 25.00
Enter the sum of lines F and G	**Total due to ACHA:**			$_____

III. 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).

IV. REPRESENTATIVE INFORMATION

9. 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 _____

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.

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, please log in to your online account and update your preferences once you receive your welcome email.

11. 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 _____

12. 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
☐ White (non Hispanic)
☐ Asian/Pacific Islander
☐ African American
☐ Native American
☐ Hispanic/Latino
☐ Other_____

Gender
☐ Female
☐ Male
☐ Transgender

Age
☐ 25 and under
☐ 26 - 40
☐ 41 - 64
☐ 65 and over

13. Select a section affiliation: The designated RMI is granted a FREE ACHA individual membership and therefore may select one section (check one). Members have access to the web pages of all sections.

☐ Administration
☐ Advanced Practice Clinicians
☐ Clinical Medicine
☐ Health Promotion
☐ Mental Health
☐ Nurse-Directed Health Services
☐ Nursing
☐ Pharmacy

14. 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
☐ Healthy Campus Coalition
☐ LGBTQ+ Health Coalition
☐ Sexual Health Education and Clinical Care Coalition
☐ Spirituality, Religion, and Student Health Coalition
☐ Student Health Insurance/ Benefits Plans Coalition
☐ Travel Health Coalition
☐ Wellness Needs of Military Veteran Students Coalition

Continue to page 4 to enter Student Representative information

V. STUDENT REPRESENTATIVE INFORMATION

15. 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. 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 _____

16. Review preferences carefully:

☐ Check here to be excluded (opt-out) from **mailing label** runs requested by outside companies/groups.

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

☐ Administration ☐ Clinical Medicine ☐ Mental Health ☐ Nursing
☐ Advanced Practice Clinicians ☐ Health Promotion ☐ Nurse-Directed Health Services ☐ Pharmacy

18. 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? _____

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

Place of Employment _____

20. 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?

- ☐ **Calculate your total dues and add application fee**
- ☐ **Include your payment**
- ☐ **Include a copy of this completed application**
- ☐ **Include proof of student status if selecting a student member representative**