# Sustaining Membership Application for New Members

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

## I. GENERAL INFORMATION

***Note: All sustaining membership applications are subject to review and approval by the ACHA Executive Committee.***

Organization Name ______________________________________________

Representative First Name ____________________ Last Name ____________________ Middle Initial _____

Title ______________________________ Professional Designation/Credential (s) ____________________

Mailing Address ______________________________________________

City ____________________ State ______ Zip ________ Email ______________________________

Phone ____________________ Fax ____________________

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

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

**Select as many section affiliations as you like:**

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

**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.

**Reason(s) for joining:** ______________________________________________

## II. ORGANIZATIONAL INFORMATION

**Furnish company background, including products and services. Alternately, you can provide a direct link to your website "About" page.**

______________________________________________

______________________________________________

## III. MEMBERSHIP CATEGORY

☐ **Nonprofit Sustaining Membership - $500/year**: Any nonprofit or charitable giving association or organization interested or involved in the college health field but not directly associated with a profit-making business. ACHA reserves the right to request proof of non-profit status.
☐ **$25** – I would like to receive mailed copies of the ***Journal of American College Health*** (full online access is included with your membership)

☐ **For-Profit Sustaining Membership – $4,000/year**: Any for-profit association, organization, or business interested or involved in the college health field.
☐ **$25** – I would like to receive mailed copies of the ***Journal of American College Health*** (full online access is included with your membership)

## IV. DUES

Enter the amount from the membership category selected above. **Total due to ACHA:** $______________

## V. 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 indicated above. ACHA memberships are final and non-refundable.***

9/18/2020 Email completed form to membership@acha.org **OR** Fax: (410) 859-1510 **OR** Mail form with check payment to: ACHA PO Box 419224 Boston, MA 02241-9224