ACHA-PSAS

American College Health Association
Patient Satisfaction Assessment Service

Order Form

BILL TO

Name________________________________Title________________________________

Institution __________ ACHA Institutional Member ID #__________________

Street Address____

City/State/Zip____

Phone________________________________E-mail ____________________________

CONTACT PERSON

Name________________________________Title________________________________

Institution __________ ACHA Institutional Member ID #__________________

Street Address (**NO P.O. BOX #s**)____________________________________

City/State/Zip____

Phone________________________________E-mail ____________________________

Indicate school year participating in: ❑ **BEGINNING FALL Year**__________________

SURVEY FEES FOR FALL AND SPRING with one combined report in Spring

Pricing for Participation	**Quantity**	**ACHA Institutional Members**	**ACHA Non-Institutional Members**	**Amount**
Participation Fee and Report Package: 1) Link to survey results while in progress 2) Institutional Report 3) Institutional Data Set in Excel and SPSS 4) Reference Group Report		$500.00[1]	$750.00[1]	
Each Additional 15 Provider Names		$25.00	$45.00	
5 Custom Questions[2]		$700.00	$1,000.00	
Optional Mid-Year Institutional Report		$150.00	$300.00	
			TOTAL	

PAYMENT

☐ Institutional Purchase Order #________________________ ☐ Check or money order payable to ACHA

☐ Visa ☐ MasterCard ☐ American Express

Card #______________________Exp. Date____________ CSV (from back of card)__________Billing Zip __________

Cardholder's Name______________________________ Signature ______________________________

[1] Includes customizing survey for each student health service plus 15 provider names.

[2] For surveys that include more than five custom (extra) questions, the pricing will be the same but the results of the custom questions will NOT be included in the Institutional Report. The custom questions will be included in the SPSS data files. There is a limit of 15 custom (extra) questions.

Remittance Address for Payment (You may fax this form if paying by credit card or PO):
ACHA-PSAS, P. O. Box 419224, Boston, MA 02241-9224 Fax: (410) 859-1510

Please be sure to include the order form when sending payment to the address above.
For more information, contact Valerie Hartman at vhartman@acha.org or (443) 270-4552.

www.acha.org/PSAS