



AMERICAN
COLLEGE
HEALTH
ASSOCIATION

Institutional Membership Application for New Members

For the membership year January 1, 2026, through December 31, 2026

EMAIL COMPLETED FORM TO: membership@acha.org 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 _____

City _____ State _____ Zip _____ Country (if not USA) _____

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

How did you hear about ACHA? (e.g., ACHA promo postcard, colleague, social media, another association, etc.)

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
<input type="checkbox"/>	Level 1	No health or well-being program	\$450
<input type="checkbox"/>	Level 2	\$25,000 - \$49,999	\$490
<input type="checkbox"/>	Level 3	\$50,000 - \$99,999	\$550
<input type="checkbox"/>	Level 4	\$100,000 - \$199,999	\$680
<input type="checkbox"/>	Level 5	\$200,000 - \$299,999	\$800
<input type="checkbox"/>	Level 6	\$300,000 - \$499,999	\$920
<input type="checkbox"/>	Level 7	\$500,000 - \$699,999	\$1,150
<input type="checkbox"/>	Level 8	\$700,000 - \$899,999	\$1,360
<input type="checkbox"/>	Level 9	\$900,000 - \$999,999	\$1,900
<input type="checkbox"/>	Level 10	\$1M - \$1.4M	\$2,200
<input type="checkbox"/>	Level 11	\$1.5M - \$1.9M	\$2,700
<input type="checkbox"/>	Level 12	\$2M - \$2.9M	\$3,200
<input type="checkbox"/>	Level 13	\$3M - \$9.9M	\$3,750
<input type="checkbox"/>	Level 14	Greater than \$10M	\$4,250

(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, coalitions, 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 an **online subscription** to the *Journal of American College Health* as well as access to archives of past issues.

4. Please complete the following information (select all that apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> Administrator | <input type="checkbox"/> Medical Records Specialist | <input type="checkbox"/> Physician Assistant |
| <input type="checkbox"/> Computer Specialist | <input type="checkbox"/> Nurse | <input type="checkbox"/> Physician (specialty _____) |
| <input type="checkbox"/> Dietitian/Nutritionist | <input type="checkbox"/> Nurse Director | <input type="checkbox"/> Psychiatrist |
| <input type="checkbox"/> Faculty | <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Psychologist or Counselor |
| <input type="checkbox"/> Health Educator | <input type="checkbox"/> Pharmacist | <input type="checkbox"/> Social Worker |
| | | <input type="checkbox"/> 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.

<u>Ethnicity</u>	<u>Birthday</u>
<input type="checkbox"/> African American <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native American <input type="checkbox"/> White (non-Hispanic) <input type="checkbox"/> Other _____	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)

- | | | | |
|---|--|---|-----------------------------------|
| <input type="checkbox"/> Administration | <input type="checkbox"/> Clinical Medicine | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Nursing |
| <input type="checkbox"/> Advanced Practice Clinicians | <input type="checkbox"/> Health and Well-Being Executive Leaders | <input type="checkbox"/> Nurse Administrators | <input type="checkbox"/> Pharmacy |
| | <input type="checkbox"/> Health Promotion | | |

Secondary section(s): (optional)

- | | | | |
|---|--|---|-----------------------------------|
| <input type="checkbox"/> Administration | <input type="checkbox"/> Clinical Medicine | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Nursing |
| <input type="checkbox"/> Advanced Practice Clinicians | <input type="checkbox"/> Health and Well-Being Executive Leaders | <input type="checkbox"/> Nurse Administrators | <input type="checkbox"/> Pharmacy |
| | <input type="checkbox"/> Health Promotion | | |

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

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Alcohol, Tobacco, and Other Drugs Coalition | <input type="checkbox"/> Faculty and Staff Health and Wellness Coalition | <input type="checkbox"/> LGBTQ+ Health Coalition | <input type="checkbox"/> Sports Medicine Coalition |
| <input type="checkbox"/> Campus Safety and Violence Coalition | <input type="checkbox"/> Historically Black Colleges & Universities (HBCU) | <input type="checkbox"/> Public Health Surveillance, Preparedness, and Response | <input type="checkbox"/> Student Health Insurance/ Benefits Plans Coalition |
| <input type="checkbox"/> Community College Health Coalition | <input type="checkbox"/> Integrated College Health Coalition | <input type="checkbox"/> Sexual Health Coalition | <input type="checkbox"/> Travel Health Coalition |