AMERICAN COLLEGE HEALTH ASSOCIATION

Institutional Membership Application for New Members

For the membership year January 1, 2027, through December 31, 2027

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
☐	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

(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):

☐ Administrator
☐ Computer Specialist
☐ Dietitian/Nutritionist
☐ Executive Leadership
☐ Faculty
☐ Health Educator
☐ Health Promotion
☐ 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 and Well-Being Executive Leaders
☐ Health Promotion
☐ Mental Health
☐ Nurse Administrators
☐ Nursing
☐ Pharmacy

Secondary section(s): (optional)

☐ Administration
☐ Advanced Practice Clinicians
☐ Clinical Medicine
☐ Health and Well-Being Executive Leaders
☐ 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
☐ Faculty and Staff Health and Wellness Coalition
☐ Historically Black Colleges & Universities (HBCU)
☐ Integrated College Health Coalition
☐ LGBTQ+ Health Coalition
☐ Public Health Surveillance, Preparedness, and Response
☐ Sexual Health Coalition
☐ Sports Medicine Coalition
☐ College Health Insurance Policy and Services Coalition
☐ Travel Health Coalition