



NATIONAL COLLEGE HEALTH ASSESSMENT

ACHA-NCHA Survey Order Form

BILL TO

Name _____ Title _____
Institution _____ ACHA Institutional Member ID # _____
Street Address _____ City/State/Zip _____
Phone _____ E-mail _____

PRIMARY CAMPUS CONTACT PERSON

Name _____ Title _____
Institution _____ Campus Location (City/State/Zip) _____
Phone _____ E-mail _____

SURVEY PRODUCTS

Indicate if participating in ☐ Fall or ☐ Spring Year _____

Sample size (students invited to take the survey):	ACHA Institutional Member Price	ACHA Non-Institutional Member Price	Total
Up to 5,000 students	\$2,500	OR \$3,750	= _____
5,001 - 10,000 students	\$3,500	OR \$5,250	= _____
10,001 - 20,000 students	\$4,500	OR \$6,750	= _____
20,001 or more students	\$5,500	OR \$8,250	= _____
Community Colleges/HBCU's/Tribal Colleges	\$1,500	OR \$2,250	= _____

☐ Please check here to **OPT OUT** of the three (3) NCHA firearm questions (U.S. schools only)

Please note 5 reminders, a standard thank you message, and 1 report package are already included in the fees above.

	Quantity	ACHA Institutional Member Price	Non-Institutional Member Price	Total
Additional report package(s)	_____ X	\$400 OR	\$600	= _____
For extra custom questions, please contact ACHA-NCHA Program office for a quote.				= _____

Optional customizations (member price/non-member price):

Select one option (\$50/\$75); select up to 3 options (\$100/\$150); select unlimited options (\$300/\$450)

<input type="checkbox"/> Custom thank you email	<input type="checkbox"/> Custom end of survey page	<input type="checkbox"/> Custom "from" name	<input type="checkbox"/> Custom "from" email address	<input type="checkbox"/> Custom first page of survey
<input type="checkbox"/> Custom re-direct link	<input type="checkbox"/> Include logos or images	<input type="checkbox"/> Personalize with preferred first names	<input type="checkbox"/> Use different reminder letters	Total = _____

Total Amount Due

PAYMENT (Invoice/receipt will be emailed to person entered in "BILL TO" above)

☐ 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 _____

Please email order form with credit card payment to: ncha@acha.org

Remittance address for check payment:

ACHA-NCHA P. O. Box 419224, Boston, MA, 02241-9224 Please be sure to include this order form with your payment.



AMERICAN
COLLEGE
HEALTH
ASSOCIATION