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 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)

☐ Custom thank you email	☐ Custom end of survey page	☐ Custom "from" name	☐ Custom "from" email address	☐ Custom first page of survey
☐ Custom re-direct link	☐ Include logos or images	☐ Personalize with preferred first names	☐ 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