

**Recruited By: (please provide first and last name)**

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**Please complete ALL 5 sections of the application and return ALL 3 pages of the application to AHP.**

1. Membership Type (please select one):

**AHP Individual Membership**

*Individual Membership* is available to those individuals employed by any voluntary, not-for-profit or government health care organization or institution whose responsibilities are directly related to resource development. Individual Membership is \$430. **Individual membership is non-transferable.**

**AHP Institutional Membership**

*Institutional Membership* is available to any voluntary, not-for-profit or government health care organization or institution. **All development professionals must be included to qualify for institutional membership.** Dues are determined based on the number of development professionals within the institution. See the Annual Dues Schedule.

**Annual Dues Schedule\***

Development Professionals	Dues
2-3	\$973
4-5	\$1,459
6-7	\$1,946
8-9	\$2,432
10-11	\$3,027
12 or more	\$3,277 plus \$250 for each additional member

\*All institutional dues are due on June 30 of each year. If you are joining on a date other than June 30, dues will be pro-rated. Contact AHP at (703) 532-6243 for specific information.

**AHP Associate Membership**

*Associate Membership* is available only to those individuals who are interested in the purposes, programs, or activities of the Association, but are not associated with a health care organization. This membership category also includes students. **Consultants and vendors are not eligible for this membership and should contact AHP for affiliate membership information.** Associate membership is \$315 and non-transferable.

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**AHP Member-Get-A-Member Application**  
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2. Membership Information

\_\_\_\_\_  
Name of Health Care Institution

\_\_\_\_\_  
Name

Please check: \_\_\_Ms. \_\_\_Mrs. \_\_\_Miss \_\_\_ Mr. \_\_\_ Dr. \_\_\_Other

\_\_\_\_\_  
Title

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Fax

\_\_\_\_\_  
Email

\_\_\_\_\_  
Institution's Web Address

For Institutional Membership *ONLY* — *Roster REQUIRED*

Name of Primary Contact (if different from above): \_\_\_\_\_

Number of development professionals joining: \_\_\_\_\_

**Attach additional sheets to list all development professionals** at your institution, including all contact information (mailing address, phone, fax and email). All development professionals must be included to qualify for institutional membership.

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3. Payment

Initial Dues must be included with this application (payable in U.S. funds)

**Membership dues for individual are \$430. Please contact AHP for prorated dues for new institutional membership.**

Enclosed is my check for \$ \_\_\_\_\_

Please charge \$ \_\_\_\_\_ to:

\_\_\_\_ Visa      \_\_\_\_ MC      \_\_\_\_ AMEX

Account Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Signature of Card Holder: \_\_\_\_\_

4. Signature

I am/we are applying for membership in the Association for Healthcare Philanthropy and will abide by its Bylaws, uphold its Statement of Professional Standards and Conduct, support its goals, and pay established annual dues.

Signature: \_\_\_\_\_

5. Mail ALL 3 pages of the application with payment to:

Association for Healthcare Philanthropy  
313 Park Avenue, Suite 400  
Falls Church, VA 22046

Or fax ALL 3 pages to:

703-532-7170 Fax

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