

CONTACT INFORMATION

I am student I am a Foundation Board Member I am a Foundation/School

Name _____

Title _____

Company Name _____

Address _____

City _____ State/Province _____ Zip _____

Country _____

Email _____

Twitter _____ Fax _____

Office Phone _____ Mobile _____

I would prefer to not receive 3rd party communications.

PERSONAL DEMOGRAPHICS

Year Born (MM/DD/YYYY) _____ Sex: Male Female

Year started career in development (i.e. 1995) _____

Year started career in health care development (i.e. 1995) _____

Primary responsibilities include (check as many as apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Annual Gifts | <input type="checkbox"/> Foundations/Corporations | <input type="checkbox"/> Planned Giving |
| <input type="checkbox"/> Capital Campaigns | <input type="checkbox"/> Major Gifts | <input type="checkbox"/> Special Events |
| <input type="checkbox"/> Communications | <input type="checkbox"/> Marketing | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Direct Mail | | |

Primary Role (Select the primary role that best describes you. Select ONLY 1.)

- | | | |
|--|--|---|
| <input type="checkbox"/> Administrative Assistant | <input type="checkbox"/> Development Coordinator | <input type="checkbox"/> Major Gifts Officer |
| <input type="checkbox"/> Annual Giving Officer | <input type="checkbox"/> Development Officer | <input type="checkbox"/> Planned Giving Officer |
| <input type="checkbox"/> Campaign Officer | <input type="checkbox"/> Director of Development | <input type="checkbox"/> President/CEO |
| <input type="checkbox"/> Chief Development Officer | <input type="checkbox"/> Donor Relations | <input type="checkbox"/> Prospect Researcher |
| <input type="checkbox"/> Chief Financial Officer | <input type="checkbox"/> Coordinator | <input type="checkbox"/> Special Events Officer |
| <input type="checkbox"/> Chief Operating Officer | <input type="checkbox"/> Executive Director | <input type="checkbox"/> Vice President |
| <input type="checkbox"/> Database Manager | <input type="checkbox"/> Grant Writer | <input type="checkbox"/> Other _____ |

INSTITUTIONAL DEMOGRAPHICS

Name of Healthcare/Hospital System (if applicable) _____

Chief Executive Officer _____

Institutional Web Address _____

Number of Beds _____ Not Applicable

Service Population (estimate) _____

Geography

- | | | |
|---------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Local | <input type="checkbox"/> Rural | <input type="checkbox"/> State |
| <input type="checkbox"/> Metropolitan | <input type="checkbox"/> Regional | <input type="checkbox"/> National |

Program Size

- | | |
|-----------------------------------|---|
| <input type="checkbox"/> Small | <input type="checkbox"/> Large |
| <input type="checkbox"/> Mid-size | <input type="checkbox"/> Regional Network |

Healthcare Facility Type

- | | | |
|--|---|--|
| <input type="checkbox"/> Children's Hospital | <input type="checkbox"/> Long Term Care | <input type="checkbox"/> System |
| <input type="checkbox"/> Community Hospital | <input type="checkbox"/> Med. School | <input type="checkbox"/> Teaching |
| <input type="checkbox"/> Community Med. Ctr. | <input type="checkbox"/> Nursing/Retirement Home | <input type="checkbox"/> Tertiary Hospital |
| <input type="checkbox"/> Government | <input type="checkbox"/> Psychiatric | <input type="checkbox"/> University Based |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Safety Net/Public Hospital | <input type="checkbox"/> VNA |

Associate Membership is available to Students, Board Members, Development professionals outside North America and others not eligible for Individual, Institutional or Affiliate membership. Membership is for 12 or 24 months and begins the month after your application and dues are received.

Please fill out the application and return with payment to AHP Membership Services at

**2511 Jefferson Davis Hwy, Suite 810
Arlington, VA 22202**

Fax: 703-532-7170

or apply online at
www.ahp.org/membership

ANNUAL DUES

12 Months—\$324 24 Months—\$630

VOLUNTARY CONTRIBUTIONS

Your gift makes a difference. Support the AHP Annual Fund today!

- | | |
|-------------------------------|--------------------------------------|
| <input type="checkbox"/> \$25 | <input type="checkbox"/> \$100 |
| <input type="checkbox"/> \$50 | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> \$75 | |

METHOD OF PAYMENT

- | | |
|--|-------------------------------------|
| <input type="checkbox"/> Check/Money Order | <input type="checkbox"/> Mastercard |
| <i>(Payable to AHP)</i> | |
| <input type="checkbox"/> Visa | <input type="checkbox"/> AmEx |

Account Number _____

Exp. Date (MM/YY) _____ CVC: _____

Signature _____

Date _____

For your convenience, payment for membership dues or benchmarking payments may be made to AHP by mail, phone, fax, or through AHP's website. Please note that AHP cannot control the handling of payment information sent to AHP by way of mail or email. AHP will not be responsible for any damages or loss incurred by you if you choose to send payment information (including, without limitation, credit card information) to AHP by way of mail or email. You therefore accept sole responsibility for any damage or loss resulting from your use of such communication methods. Please review our Privacy Policy found at http://www.ahp.org/Home/Privacy_Policy/Home/Privacy_Policy.aspx for a summary of our practices related to the collection and use of personal information.