LOUISIANA HOSPITAL ASSOCIATION

APPLICATION FOR ASSOCIATE MEMBERSHIP

Date_____

Associate Membership shall be non-voting and shall consist of the following:

(a) Other healthcare institutions, except hospitals, that provide for the care of patients requiring an inpatient stay.

(b) Dispensaries, clinics, home health agencies and other similar organizations for the diagnosis and treatment of the sick and injured, but not rendering inpatient care.

(c) Groups formally organized for the construction of a new health care facility.

Our company wishes to become an Associate Member of the Louisiana Hospital Association, and in return for the annual fee indicated below, enjoy the following privileges:

1. Receive our weekly publication ***IMPACT WEEKLY*** via email.
2. Attend educational offerings at the Associate Member rate.
3. Eligibility to participate in the LHA Trust Funds which provides affordable Professional Liability, General Liability and Workers' Compensation Coverage.

Annual Membership Fee *(includes one company representative)***: $2,500/yr.**
Annual Rate for each additional company representative: $125.00/yr.

Annual fee for Members of the LHA Trust Funds is based on a percentage of premium(s); contact Carla Juneau at 225.368.3810 / carlajuneau@hsli.com for quote.

Enclosed is our check in the amount of $_____, which includes the annual

Membership fee of $2,500 and $_____ for _____ additional representatives.

Signed by_____

Company Name_____

COMPANY ADDRESS_____

CITY, STATE, ZIP_____

TELEPHONE_____WEBSITE_____

TYPE OF BUSINESS ENGAGED IN_____

_____

One Primary Representative is included in $2,500 annual membership fee

PRIMARY REPRESENTATIVE_____

TITLE_____

ADDRESS_____

CITY, STATE, ZIP_____

PHONE(____)_____EMAIL_____

ADDITIONAL REPRESENTATIVES @ *$125.00 each*

NAME_____

TITLE_____

ADDRESS_____

CITY, STATE, ZIP_____

PHONE(____)_____EMAIL_____

NAME_____

TITLE_____

ADDRESS_____

CITY, STATE, ZIP_____

PHONE(____)_____EMAIL_____