



FOR NACHC USE ONLY:

Batch # _____

IS # _____

7501 Wisconsin Ave, Suite 1100W • Bethesda, MD 20814 • ☎ 301.347.0400 • 📠 301.347.0459

NACHC ASSOCIATE MEMBERSHIP APPLICATION

Associate Membership

This category is a non-voting category of membership, open to any not-for profit primary health care organization which is committed to the mission and goals of NACHC and which does not meet the criteria for Organizational Membership.

Annual Dues: \$750.00

Name of Organization: _____

Key Contact Person: _____

Title: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone #: (____) _____ Fax #: (____) _____

E-Mail Address: _____ URL: _____

Membership Dues Payment Information:

We wish to pay our dues With the check enclosed in the amount of \$ _____
(Payment should be mailed to the address at the top of the page)

By charging the credit card number listed below

Type of Credit Card: American Express Diners Club MasterCard Visa

Card Number: _____

Expiration Date: _____ Amount: _____

Name on Card: _____

Signature: _____

Confirmation on Membership will be mailed within two weeks of receipt of membership dues payment. However, member benefits begin immediately upon receipt of dues payment. For questions, please contact the Membership & Marketing Department.