



ACHCA

American College of
Health Care Administrators

RETIRED STATUS MEMBERSHIP APPLICATION

Member Profile:

ACHCA Member ID (if known) _____ Current Status Member Fellow

Full Name _____ Phone Number _____ Retirement Date _____

Most Recent Title and Employer _____

If you have not recently updated your address within the ACHCA Member Portal, please update your information. If you prefer, call ACHCA Membership at (800) 561-3148 to update over the phone.

Address _____ City _____ State _____ Zip _____

E-mail Address _____

You must meet the following requirements to be eligible for Retired status:

- I am currently an ACHCA Member or Fellow, and have been for at least five years.
- I am retired from healthcare administration.
- I am at least 55 years of age.

By submission of this membership application, I attest that the information I have provided is true, accurate, and complete. In addition, I have read and will continue to adhere to the ACHCA Code of Ethics. (www.achca.org)

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Voting Memberships

National Dues

Retired

Current voting members of continuous 5+ years, who have retired from healthcare administration and are at least 55 years of age. Must submit statement of attestation for proof of retirement with no remuneration for administrative services.

\$100

Retired Fellow

Current voting members who have been a Fellow in good standing of 5+ years, are 55+ years of age, and have retired from healthcare administration. Must submit statement of attestation of proof of retirement with no remunerations for administrative services.

\$80

Payment Information

Dues:

\$_____ Dues from above (Primary Chapter Dues are included)

\$_____ Additional Chapter Dues (\$30.00 per additional chapter); Name of additional chapter(s): \$_____ Total Remitted

_____ I have enclosed a check payable to ACHCA. Check # _____

MAIL application & check payment to: ACHCA Membership

1101 Connecticut Ave NW, Ste. 450, Washington, DC 20036

Once you have everything complete and ready to go, you can submit your ACHCA membership application by e-mail (membership@achca.org), or send credit card payment by secure fax (866-874-1585).

Paying by credit card:

Please charge my: ___American Express ___MasterCard ___Visa ___Discover

Account Number: _____ Expiration Date: _____ Security Code: _____ Name of Cardholder:

Signature of Cardholder:

Payment Processing Disclosure: Memberships are non-refundable. Charges are processed through our merchant services provider, Authorize.net. The item may appear on your statement as ACHCA.

Questions? Contact: membership@achca.org or (202) 536-5120

Thank you for submitting your application. We appreciate your leadership in the long term care profession!