

ASSOCIATE MEMBER APPLICATION

ORGANIZATION NAME:			TELEPHONE NUMBER:
ORGANIZATION ADDRESS:			FAX NUMBER:
CITY:	STATE:	ZIP CODE:	COMPANY WEBSITE:
ORGANIZATION REPRESENTATIVE:			REPRESENTATIVE E-MAIL ADDRESS:
TITLE / POSITION:			REPRESENTATIVE EXTENSION:

Please provide a business reference:

ORGANIZATION'S NAME:	TELEPHONE NUMBER:	CONTACT PERSON:
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Please provide a brief description of your company and the services provided:

Please include a copy of most recent Annual Report or copies of promotional materials.

ASSOCIATE MEMBER DUES STRUCTURE: (Check One) <input type="checkbox"/> \$ 800.00 Annual Membership (January - December) <input type="checkbox"/> \$ 575.00 Pro-Rated (Applications received after July 1st, covers through December 31st)	PAYMENT METHOD: <input type="checkbox"/> AMERICAN EXPRESS <input type="checkbox"/> VISA	<input type="checkbox"/> CHECK ENCLOSED <input type="checkbox"/> MASTERCARD <input type="checkbox"/> DISCOVER
	Credit Card Number:	Expiration Date:
Please Return Application and Payment to: Associate Member Program NYSHFA / NYSCAL 33 Elk Street, Suite 300 Albany, NY 12207-1010	Cardholder Name:	Signature:
	Credit Card Billing Address:	

The above named organization hereby makes application for Associate Membership in the New York State Health Facilities Association, Inc. (NYSHFA) / New York State Center for Assisted Living (NYSCAL) and agrees, if accepted, to support the Association's goals and objectives. The organization agrees to pay established dues in a timely manner.

Signature: _____ Print Name: _____ Date: ___/___/___