PARTNERS OF WHA
APPLICATION FOR MEMBERSHIP

Date: ______________

Organization Name: ______________________________

We hereby make application for membership to Partners of WHA

We understand that our membership is renewed upon payment of annual dues. Payment of $______ is. ( ) enclosed or ( ) previously submitted. Second year dues will be reduced by pro-rating the number of months remaining in your membership at the close of the fiscal year. Payments should be made to Partners of Wisconsin Hospital Association, Inc. and directed to the Membership Chair.

Name ______________________________
Title ______________________________
Address ______________________________
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Telephone ______________________________
Email ______________________________

Other
Name ______________________________
Title ______________________________
Address ______________________________
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Telephone______________________________
Email ______________________________

Please return a copy of this application to the President of WHA