Application for Allied Membership in Healthcare Council of Western Pennsylvania

This application for Allied Membership in Healthcare Council of Western Pennsylvania is authorized by the individual whose signature appears on the bottom of page 2. In submitting this Application, Applicant agrees to the Terms and Conditions of Allied Membership as herein outlined

Membership Information (Please print or type)

Chief Executive Officer_____ E-mail Address_____

Executive Secretary_____ E-mail address_____

Key Contact (if different from CEO)_____ E-mail address_____

Title_____

Organization_____

Street Address_____

_____

Mailing Address (if different from above)_____

_____

Telephone Number_____ Fax Number_____

Web Site Address_____

(Please note that the Chief Executive Officer or the Key Contact will receive all Allied Membership information and communications from Healthcare Council.)

Please provide a brief statement of the principal purpose and the function(s) of your organization, such as your Mission Statement, and indicate your relationship to the western Pennsylvania health care field community.

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Terms and Conditions of Allied Membership in Healthcare Council of Western Pennsylvania

► Applicant agrees that it meets one of the following Allied Membership eligibility criteria:

1. A professional services firm, business and/or private consultant or consulting practice located in western Pennsylvania that provides services to and works directly with hospitals and health care organizations in western Pennsylvania.
2. A non-profit health-related organization, community service agency or community health service that serves western Pennsylvania and addresses health-relates needs.
3. A post-secondary education institution that offers health-related programs.

► Applicant agrees to pay the specified annual dues as a condition of becoming and remaining an Allied Member of Healthcare Council. Annual dues of $1,000.00 are billed in advance of each calendar year. Dues must be paid in one installment, unless other arrangements have been made in advance. Dues paid shall entitle Applicant to certain benefits, including networking opportunities, access to industry information through surveys, reports and attendance at education programs and meetings, and opportunities for increased visibility with HCWP members. These benefits may change, from time to time, at the sole discretion of Healthcare Council. Applicant agrees and understands that, by becoming an Allied Member, there is no guarantee of economic benefit to its organization, and other organizations similar in nature to Applicant may also become Allied Members.

► Applicant agrees that all data, information and educational materials provided to it or its employees or agents by Healthcare Council is strictly confidential and is intended solely for its private, non-commercial use. Any reproduction, distribution or other use is prohibited without the advance written permission of Healthcare Council.

► Applicant agrees to abide by applicable Healthcare Council by-laws, conditions, rules and regulations. Applicant further acknowledges and asserts that it qualifies as an Allied Member in compliance with the following Healthcare Council by-laws:

> Article III Section 2. Allied members shall be entities not eligible to become institutional members of Healthcare Council, that provide care, education, training, health-related human services to people, or engage in activities or endeavors with health care institutions in western Pennsylvania. They would be vital parts of the community health network and would share objectives of health care institutions and the Healthcare Council of Western Pennsylvania.

► Applicant understands that this application for Allied Membership in Healthcare Council must be approved in accordance with the Healthcare Council By-laws. Applicant agrees that, if Healthcare Council requires additional information from Applicant in order to make a determination regarding this Application, it will provide said information to Healthcare Council upon request.

Signature_____ Name (please print)_____

Title_____ Date_____

Referred by (if applicable)
Name_____ Organization_____

Mail completed application with check for annual dues to:
Patricia J. Raffaele, Vice President, HCWP, 500 Commonwealth Drive, Warrendale, PA 15086-7513