



# Arizona Health Care Association Membership Application

## Business Affiliate Member

Dues \$625.00 Per Year

Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Email: \_\_\_\_\_

Website: \_\_\_\_\_

Type of Business: \_\_\_\_\_

### Arizona Contact Information

Representative's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Email: \_\_\_\_\_

Signature: \_\_\_\_\_ Title: \_\_\_\_\_

Date: \_\_\_\_\_ Referred By: \_\_\_\_\_

Do not write below this line

Board Action: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

### Mail this application to:

Arizona Health Care Association, 1440 East Missouri Avenue, Suite C-102,  
Phoenix, AZ 85014-2458. Phone: 602.265.5331 Fax: 602.265.4401