



Membership Application

Date: _____
 Name: _____
 Title: _____
 Organization: _____
 Business Address: _____
 Telephone/Fax: _____
 E-Mail: _____
 Years of service in healthcare: _____

Which two best describe your responsibilities (rank #1 and #2):

- | | |
|---|---|
| <input type="checkbox"/> Planning | <input type="checkbox"/> Physician Relations/Recruiting |
| <input type="checkbox"/> Sales | <input type="checkbox"/> Physician Practice Management |
| <input type="checkbox"/> Marketing | <input type="checkbox"/> Network Development |
| <input type="checkbox"/> Financial Planning | <input type="checkbox"/> Managed Care Contracting |
| <input type="checkbox"/> Other (specify) | |

Membership Category Applied for:

Annual Dues

- | | |
|---|--|
| <input type="checkbox"/> Primary Member | \$ 125.00 |
| <input type="checkbox"/> Corporate Member (up to 4 per organization)* | \$ 300.00 (complete a separate form for each member) |
| <input type="checkbox"/> Student Member | \$ 75.00 |

* \$75.00 per person additional corporate members

Program Interests:

- | | |
|---|---|
| <input type="checkbox"/> a. Managed Care Issues | <input type="checkbox"/> e. ElderCare |
| <input type="checkbox"/> b. Strategic Planning | <input type="checkbox"/> f. Network Integration |
| <input type="checkbox"/> c. Physician Network Development | <input type="checkbox"/> g. Complementary Medicine |
| <input type="checkbox"/> d. Senior Living | <input type="checkbox"/> h. Surviving as a Community Hospital |
| | <input type="checkbox"/> i. Other _____ |

Are you interested in participating in NESHS's Program and Membership Committees? yes no

Please send or e-mail this application to Donna Powell, NESHS Administrator, admin@neshs.org

Mail your check (payable to NESHS) to:

NESHS
 P.O. Box 500
 Westford, MA 01886

Or you may apply and pay online at www.neshs.org

Thank you for joining NESHS!

Would you recommend any of your colleagues for membership in NESHS?

Name: _____
 Organization: _____
 Telephone: _____ E-mail: _____