

MEMBERSHIP APPLICATION

Type of Membership Level Requested:

- Organizational
 Corporate
 Affiliate/Look-Alike
 Associate
 Individual

Applicant Information

APPLICANT'S NAME:	TITLE (FOR ORGANIZATIONAL, CORPORATE, AFFILIATE, OR ASSOCIATE LEVEL):
NAME OF ORGANIZATION (FOR ORGANIZATIONAL, CORPORATE, AFFILIATE, OR ASSOCIATE LEVEL):	EMAIL:
MAILING ADDRESS:	TELEPHONE:
CITY: STATE: ZIP:	FAX:

NOTE: Membership applications are presented to the Board of Directors on the 3rd Wednesday of the following month the application is received.

Membership Levels	Annual Dues
Organizational Member (Based on Annual Budget)	
<input type="checkbox"/> Up to \$4,999,999	\$2,500
<input type="checkbox"/> \$5,000,000 to \$9,999,999	\$3,500
<input type="checkbox"/> \$10,000,000 +	\$4,500
Corporate Member	
<input type="checkbox"/>	\$3,000
Affiliate/Look-Alike Member	
<input type="checkbox"/>	\$1,000
Associate Member	
<input type="checkbox"/>	\$750
Individual Member	
<input type="checkbox"/>	\$50

Briefly describe your interest in joining the SCPHCA. For all member levels, excluding Individual, describe current partnerships/collaborations with other healthcare organizations with missions that align with the SCPHCA.

Please forward your completed application to:
Shaletta Miller (shalettam@scphca.org)

Membership Disclaimer:

Be advised that all requests for membership will be verified through the Office of Inspector General (OIG) to ensure applicant and/or Organization and its Principles, are not listed on the federal exclusion list.

FOR OFFICE USE ONLY

OIG Verified Date Verified

"Access to Quality Health Care for All of South Carolina"