



CORPORATE Membership

Membership Application

Please complete the form below and mail or fax payment to: HIMSS 6901 Eagle Way, Chicago, IL 60678-1690 | Fax: 1.312.915.9209

Corporate Information

Company \_\_\_\_\_ Date \_\_\_\_\_

Company Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Primary Contact

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Title \_\_\_\_\_

Mailing Address (if different from above) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

Phone Number \_\_\_\_\_ Email Address \_\_\_\_\_

Professional Level Please choose one that best describes your level of responsibility.

- CEO, COO, Marketing, CFO, CIO, Other (please specify), Vice President, Senior Staff/Manager, Other Senior Manager, Department Director/Head

Membership Dues (in USD) Please check one

HIMSS Asia Pacific Corporate Membership

- Gold Membership USD 5,000, Diamond Membership USD10,000

Payment

Annual dues in the amount of USD \_\_\_\_\_

are enclosed. I understand that HIMSS may deposit the enclosed dues pending consideration of this application. In the event the application is not approved, HIMSS will promptly refund my remittance.

WIRE TRANSFER

Please direct wire transfers for Asia Pacific to: JPMorgan Chase Bank. N.A. Singapore (SWIFT Code: CHASSGSG) Favoring Healthcare Information & Management Systems Society Account Number - 0172943794

CHECK

Make check or money order payable to HIMSS. Mail to: HIMSS, Finance Department 230 E Ohio Street, Suite 500 Chicago IL 60611-3269, USA

CREDIT CARD

- American Express, Discover, MasterCard, Visa

Card Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

Name on Credit Card \_\_\_\_\_ Cardholder's Signature \_\_\_\_\_

Please fax this form to +1.312.915.9209 if paying by credit card.

Authorization Please complete, then print and fax this form to +1.312.915.9209

NAME OF FIRM has agreed to join HIMSS as a Gold/Diamond\* Level Corporate Member for the 12 month period beginning MONTH YEAR.

NAME OF FIRM understands that eligibility and access to member benefits begin upon receipt of full payment. If payment is not sent with application, we authorize HIMSS to invoice our firm. We agree to pay full membership dues within 30 days and understand that we will not be eligible for benefits until our full payment is received.

Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_

\* Delete where appropriate