

**Healthcare Organization Information**

Provider Name \_\_\_\_\_ Provider Website \_\_\_\_\_

Address \_\_\_\_\_

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

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

**Primary Contact**  Mr.  Ms.  Dr.

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

Title \_\_\_\_\_

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

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

Phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_ Email \_\_\_\_\_

**HIMSS Organizational Affiliate Program Levels and Dues**

Associate (\$2,000)  Pioneer (\$4,000)  Principal (\$8,000)  Executive (\$12,000)

**Adjustment** \$ \_\_\_\_\_ *(if applicable)*.

**Total** \$ \_\_\_\_\_ annual dues.

**Payment** \$ \_\_\_\_\_ in annual dues are enclosed or **Purchase Order Number:** \_\_\_\_\_

Check Enclosed  Visa  MasterCard  American Express  Discover

Card No \_\_\_\_\_ Expiration Date \_\_\_\_ / \_\_\_\_

Cardholder's Signature \_\_\_\_\_

Name on Credit Card (please print) \_\_\_\_\_

Make checks or money orders payable to HIMSS.

Mail or fax to: HIMSS Organizational Affiliate Program • 230 E. Ohio St., Suite 500 • Chicago, IL 60611-3269 • fax: 312-915-9209

**Application may be faxed when paying by credit card.** Tax ID#: 36-3906745

**Authorization** *Please complete, then print and fax this form to: 312-915-9209.*

\_\_\_\_\_ (name of HCO) has agreed to join HIMSS as a \_\_\_\_\_ Level Organizational Affiliate for the 12 month period beginning \_\_\_\_\_ (month), \_\_\_\_\_ (year). \_\_\_\_\_ (name of HCO) understands that access to program benefits begin upon receipt of and approval of this application. If payment is not sent with application, we authorize HIMSS to invoice our firm.

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

Revised prices effective from 24 February 2009. No refund will be given for payment received before 24 February 2009