Texas Hospital Home Health Association
P. O. Box 14547
Austin, Texas 78761
Telephone 512/873-0045

MEMBERSHIP APPLICATION

Date ______________________________

Membership Category Applied For: ____ Regular ____ Corporate ____ Affiliate

REGULAR MEMBERSHIP

Name of Hospital ______________________________

Address of Hospital ______________________________

City, Zip ______________________ Phone ______________ Fax ______________

Administrator ______________________________

Name of Home Health Care Program ______________________________

Address ______________________________

City, Zip ______________________________

Phone ______________________ Fax ______________________

Program Director ______________________________

Home Health Program is: ___ in operation ___ being planned

If you have multiple home health programs, please list the locations on the reverse side of this application. Regular Membership in the THHHA is held by the hospital providing the home health care program. The hospital administrator **and** the home health program director will receive all correspondence and information provided by the association.

CORPORATE AND AFFILIATE MEMBERSHIP

Company/Organization ______________________________

Address ______________________________

City, State, Zip ______________________________ Phone: ______________

Contact Person & Title ______________________________

Type of Business/Organization ______________________________

MEMBERSHIP DUES

Regular Member: $495.00 Corporate Member: $250.00 Affiliate Member: $100.00

Make check payable to Texas Hospital Home Health Association (THHHA)
and mail to P. O. Box 14547, Austin, Texas 78761