Non-Profit Partner Membership Group Application

Group purchases are for 5 new members from the same company.

Date_____/_____/_____

Non-Profit Information

Name of Affiliate Organization Web Site

Primary Address

City State Zip Country

Phone ( ) Fax ( )

Primary Contact

□ Mr. □ Ms. □ Mrs. □ Dr.

First Name Middle Initial Last Name

Title

Mailing Address *(if different than above)*

City State Zip Country

Phone ( ) E-mail Address

Participate in Communities of Profession (Check all of interest.)

□ Clinical & Business Intelligence □ Connected Health □ Emerging Professionals □ Federal Health
□ HIT User Experience □ Health Information Exchange □ Innovation □ Nursing Informatics
□ Physician (You must have MD or DO credentials to join.) □ Senior Executive

Membership Dues *Please check one. (US dollars)*

□ Group Purchase (5) New National Memberships: $795 *(Please list individuals on the attached group form) (live in US or Canada)*

Payment *Dues must accompany this application.*

Annual dues in the amount of $_____ 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.

Total amount enclosed: $_____ □ Check Enclosed □ Visa □ Mastercard □ American Express □ Discover

Card No_____ Expiration Date _____/_____

Print Name on Credit Card_____ Cardholder's signature_____

Dues must accompany this application to activate benefits. Member benefits are made available only when payment is received in full. Make checks or money orders payable to HIMSS.

Mail to: HIMSS Membership • Lock Box 6901 • Dept 77-6901 • Chicago, IL 60678-6901
Fax to: 312-664-6143 - Application may be faxed when paying by credit card.

Dues are non-refundable and non- transferable. Tax ID Number 36-3906745

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Please list the names and email addresses for each individual included in the group purchase.

1) First Name _____ MI _____ Last Name _____

Title _____

Phone _____ Email _____

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2) First Name _____ MI _____ Last Name _____

Title _____

Phone _____ Email _____

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3) First Name _____ MI _____ Last Name _____

Title _____

Phone _____ Email _____

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□ Physician (You must have MD or DO credentials to join.) □ Senior Executive

4) First Name _____ MI _____ Last Name _____

Title _____

Phone _____ Email _____

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□ Federal Health □ HIT User Experience □ Health Information Exchange □ Innovation □ Nursing Informatics
□ Physician (You must have MD or DO credentials to join.) □ Senior Executive

5) First Name _____ MI _____ Last Name _____

Title _____

Phone _____ Email _____

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□ Federal Health □ HIT User Experience □ Health Information Exchange □ Innovation □ Nursing Informatics
□ Physician (You must have MD or DO credentials to join.) □ Senior Executive