

2020 IHCA/INCAL Associate Member Application

Questions regarding this application should be directed to Colin Hebenstreit, chebenstreit@ihca.org.

Company Name:		
Address:	City, State:	Zip:
Phone: F	ax: Website:	
Contact Person:	Contact Person's Email:	
Company Category (circle up to 3)		
Management and Operations	Facility Maintenance	Resident Care
Accounting Cost Reporting/Payment/Data Analysis Education & Training Financial Services Group Purchasing Hospital Operations HR/Staffing Legal Services Marketing Risk Management/Insurance Technology IHCA E-Newsletter Distribution L	Construction Management Emergency Preparedness and Life Safety Code Engineering, Design & Architecture Environmental Supplies & Services Fire Safety Furniture Heating & Cooling Housekeeping & Laundry Restoration & Remodeling	Behavioral Health Food Service Hospice/Home/Palliative Care Hospital Services Lab/Dialysis Services Medical Supplies & Equipment Nutrition and Fitness Oral Health Physician Services Pharmaceuticals Rehabilitation/Therapy Security/Monitoring Transportation Wound Care
Č.	ss on the distribution list for the IHCA IMPACT a _ Email Address:	
	_ Email Address: _Email Address:	
approval by the IHCA Board of Directo lobbying and other related costs are not	Title Member- Contact Colin Hebenstreit ected on an annual basis and provide Associate Mers to December 31, 2020. Please be advised that deductible for federal income tax purposes. The I	pursuant to Federal tax law dues spent on
be spent on lobbying costs for 2020. Would you like to contribute a sugge care scholarship fund? Yes No.	sted \$85 donation to the Indiana Health Care	Foundation (IHCF) to benefit the long terr
IHCA Board of Directors. Approval of services. I understand that membership rights and benefits may result in member electronic membership directory, and approved the services of the services.	lication is not a guarantee of IHCA membership a membership does not constitute endorsement by benefits are only to be used by the applicant and itship termination. If this application is approved, plicant consents to receive communications via reasociate Member Dues must accompany this embership is denied.	the IHCA of applicant or its products and/or its employees and that any misuse of membershi IHCA may use applicant's information in IHCA gular mail, email, telephone, and/or fax sent by
Signature	Date	yable to IHCAMCVisaAmex
Send application with payment to: Indiana Health Care Association Attn: Colin Hebenstreit One North Capitol, Suite 100	Name on Card: Exp. CVV Numb	per:
Indianapolis IN 46204	Billing City:Billing Zip Code:	Billing State: