

MEMBERSHIP APPLICATION

NATIONAL ASSOCIATION FOR HEALTH CARE RECRUITMENT

Name _____ Title _____
Organization _____
Address _____
Phone 1.) _____ 2.) _____ Fax _____
Email _____

- | Category | Dues |
|--|------------|
| <input type="checkbox"/> Active Membership
(a recruiter or human resources professional in any organization providing direct health care, such as a hospital, long term care, home health, military, HMO) | \$135.00 |
| <input type="checkbox"/> Associate Membership
(individuals who are not doing actual recruiting but want to support the work of health care recruiters) | \$185.00 |
| <input type="checkbox"/> Institutional Membership
(for companies interested in supporting NAHCR and who provide services or products of interest to recruiters such as advertising agency, temporary or staffing agency, publications, travel agency, applicant tracking) | \$1,100.00 |

Search firms are NOT eligible for NAHCR membership

The following section is to be completed by those who are applying for _____ active membership only. Please circle the appropriate information.

Recruit for:

Allied Health HMO Home Care Long-Term Care Nurse Physician

Employment Setting:

Home Health Hospital/Health System Rehab Long-Term Care

Sub-Acute Care Other (please specify)

Report to:

Human Resources Nursing Other (please specify) _____

NAHCR Region:

Northeastern North Central Southern Western

I am using the following method of payment for Membership dues:

My check is enclosed (payable to NAHCR): Amount \$ _____

Please charge my credit card: Amount \$ _____

Master Card/Visa/American Express Account _____

Expiration Date _____ Telephone Area Code _____

Cardholder's Name _____ Cardholder's Signature _____

NAHCR Membership must be approved by the NAHCR Office

Please return form to:

NAHCR Headquarters

1401 S. Primrose Drive

Orlando, FL 32806

Fax 407.481.2825

Questions Call 407.481.2893