Join. Network. Learn. Succeed.

2018 Membership
January 1, 2018 – December 31, 2018

Membership Application

Apply/renew online at www.neahp.org, or complete the Membership Application below.

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. ***Credentials:*** ❑ CFRE ❑ FAHP ❑ Other(s) ______________________

Name: ______________________

Title: ______________________

Organization: ______________________

Address: ______________________

City: ______________________ State: __________ Zip: ______________

Phone: ______________________ Fax: ______________________

Email: ______________________

Application Type: ❑ New ❑ Renewal

Are you a member of the Association for Healthcare Philanthropy (AHP)? ❑ Yes ❑ No

Type of organization:

❑ Academic Medical Center
❑ Affiliated Health Organization
❑ Community Hospital
❑ Hospice
❑ Long-Term Care Facility
❑ Specialty Hospital
❑ Resource Provider
❑ Visiting Nurse Association
❑ Other: ______________________

Area(s) of expertise to share with other members:

❑ Accreditation
❑ Annual Giving
❑ Board Development
❑ Capital Campaigns
❑ Consultant
❑ Corporate Giving
❑ Database Mgmt
❑ Direct Mail
❑ Donor Relations
❑ Employee Giving
❑ Gov't Relations
❑ Grants
❑ Information Systems
❑ Internet Fundraising
❑ Major Gifts
❑ Management
❑ Membership
❑ Physician Giving
❑ Planned Giving
❑ Prospect Research
❑ Public Relations
❑ Recognition
❑ Small Shop
❑ Special Events
❑ Volunteer Groups
❑ Other: ______________________

Annual Dues

Dues: $125.00

Scholarship Donation*: $__________________

Amount Due: $__________________

Who is Paying for Your Dues?

❑ I am paying personally.
❑ My organization is paying.**

* Scholarship donations are for the NEAHP Scott C. Fithian Scholarship fund. Scholarships are awarded to deserving recipients; covering NEAHP Conference registration costs as well as associated hotel fees.
** Memberships paid by the Organization remain with the Organization.

Method of Payment

❑ I am enclosing a check payable to:
New England Association for Healthcare Philanthropy
❑ Please charge my credit card the Amount Due.

❑ Amex ❑ Discover ❑ MasterCard ❑ Visa

____
Card Number

__________/__________ ______________________
Expiration Date 3- or 4-digit Security Code

____
Name on Card

____
Billing Address

Send Applications To NEAHP, 465 Waverley Oaks Road, Suite 421, Waltham, MA 02452
Phone: (781) 205-9400 Fax: (781) 647-7222 Email: info@neahp.org