MISSOURI HOSPITAL ASSOCIATION
NON-MISSOURI DISTRICT MEMBERSHIP APPLICATION

Submit to: DATE ___________________________
MISSOURI HOSPITAL ASSOCIATION
P.O. BOX 60
JEFFERSON CITY, MO 65102-0060

Name of Institution: ____

Street Address:____

Mailing Address:____

City/State/Zip:____

Phone:________________________________Fax:________________________________

Name of Chief Executive Officer: ________________________________

Title and credentials (M.D./MHA/FACHE/Mr./Ms.): ________________________

E-mail: ________________________________

Type of Facility:

______ General Acute Care ______ Rehabilitation

______ Psychiatric ______ Other (Specify: ________________________)

Type of Ownership: (Check all that apply.)

______ Not-For-Profit ______ Public ______ State ______ County

______ Investor-Owned ______ Federal ______ City ______ District

Management contract (duration and with whom):________________________________

____

Federal tax I.D. number: __________________ Number of licensed beds: __________________

Number of physicians employed: ______________________

Is the facility a Medicare provider? _______ Yes ______ No If yes, provider number: __________________

Is the facility part of a health system or network(s)? ______ Yes ______ No

If so, describe ____

____

Check accreditation(s)/certification(s):

______ DOH ______ AOA ______ JCAHO ______ Medicare ______Medicaid

List other memberships the institution holds or other associations to which the institution belongs:__________

____

____

Please attach a list of senior staff and their titles to facilitate efforts to assist the institution's management team, and provide the names of the facility's board members below.

Chairman/President: ____

Vice President: ____

Secretary: ____

Treasurer: ____

Others: ____

This institution understands that this district membership application is subject to approval by the Missouri Hospital Association Board of Trustees.

Signed: ____

Title: ____

Date: ____

Date Received:___________________________________ Date Approved: _______________________