MISSOURI HOSPITAL ASSOCIATION
INSTITUTIONAL MEMBERSHIP APPLICATION

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

DATE ____________________________

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 ____

____

Total gross expenses for last fiscal year (including depreciation and interest) $____________________________

Does the facility have a home health agency or any primary care clinics, nursing homes or other ambulatory care sites?: _______ Yes _______ No

If so, describe: ____

____

Are expenses for these sites included in the facility's expenses? _______Yes _______ No

If no, indicate expenses for these sites: ____

____

Check accreditation(s)/certification(s):

______ DHSS ______ CARF ______ CIHQ ______ DNV ______ HFAP

______ The Joint Commission ______ Medicare ______Medicaid

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

____

____

Does the institution have an auxiliary? ______ Yes ______ No

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 institutional members of the Missouri Hospital Association are voting members and that this application is subject to approval by the Missouri Hospital Association Board of Trustees.

Signed: ______________________________________

Title: ____

Date: ____

Date Received:____________________________________ Date Approved: __________________________