MISSOURI HOSPITAL ASSOCIATION
NON-MISSOURI DISTRICT MEMBERSHIP APPLICATION

Submit to:
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):

_____ DHSS  _____ CARF  _____ CIHQ  _____ DNV  _____ AAHHS
_____ The Joint Commission  _____ 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: ____________________