Consortium of Hospital-Affiliated Colleges and Universities (CHACU)

Membership Intent Data Sheet

Name of school: _____

College Chief Executive Name: _____

Title: _____

Telephone Number: _____ Fax Number: _____

Mailing Address: _____

_____

Email Address: _____

Secretary's Information

Name: _____ Phone Number: _____

Email Address: _____

Affiliating Medical Center Name: _____

Organization Status: Private ___ Public ___ Governmental ___ 501c3 Y ___ N ___
(Check all that apply) For Profit ___ Not for Profit ___

Please provide brief overview of college; programs offered; size of student body; accreditation status; etc.

_____

_____

_____

_____

As the representative of this institution, I hereby agree to pay the initial membership fee of $1,000.00 upon receipt of invoice and the annual dues in subsequent years.

_____ _____
Institution Representative (Signature) Date

_____ _____
AHSEC Current Member Sponsor (Signature) Date

Office use only

_____ _____ _____
AHSEC Approving Officer (Signature) Date Invoice Sent – Date