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**Member information** (all fields required)

Business address

Home address

NAME

TITLE

ORGANIZATION

STREET ADDRESS

CITY

STATE

ZIP

TELEPHONE

FAX

EMAIL

**Annual member dues**

Healthcare provider-based member – \$235

Consultant member – \$235

Vendor member – \$235

Student member – \$85

**Primary job category** Which title best describes your primary job category? (Please select only one)

Marketing

Physician relations

Public relations/communications

Strategic planning

**Method of payment**

Check or money order made out to: AHA/SHSMD

Visa

MasterCard

American Express

NAME OF CARDHOLDER

CARD NUMBER

EXP. DATE

SIGNATURE



SOCIETY FOR  
**Healthcare Strategy & Market Development**<sup>SM</sup>  
*of the American Hospital Association*

**To submit this application, mail completed form along with payment to:**

AHA/SHSMD, P.O. Box 75315, Chicago, IL 60675-5315 • Fax: 312.422.3609 • [www.shsmd.org/join](http://www.shsmd.org/join)

Thank you. We look forward to welcoming you into the SHSMD community.

Got questions? Contact us at 312.422.3888 or [shsmd@aha.org](mailto:shsmd@aha.org)