Personal Connected Health Alliance

MEMBERSHIP AGREEMENT

Organization Information

Please list the Organization Name and Address as it should appear on membership records and invoices (if requested by member). The listed contact will receive all communications related to PCHAlliance membership processing (payments, renewals, etc.). Please notify HIMSS/PCHAlliance should any of this information change. PCHAlliance is a business unit of HIMSS.

PRIMARY CONTACT

Title

Organization

Address 1

Address 2

City

State/Region

Zip Code

Postal Code

Country

Phone

Primary Contact Email

Organization Web Address

Organization Domain(s)

Organization services or products sold, or what function your organization serves:

Contacts

ACCOUNTS PAYABLE CONTACT

Title

Email

Phone

MARKETING/PR CONTACT

Title

Email

Phone

OTHER CONTACT #1

Title

Email

Phone

OTHER CONTACT #2

Title

Email

Phone

Annual Membership Level Selection

Our Organization is interested in the following Membership Level (please select one of the following):

- ○ **STRATEGIC MEMBERSHIP** ($25,000 USD)
- ○ **INNOVATOR MEMBERSHIP** ($7,500 USD)
- ○ **ADOPTER MEMBERSHIP** ($1,500 USD)
- ○ Association, Government, Non-Profit, Startup
- ○

Membership Term

Please indicate your desired Membership Term start month (first day of the month for the selected month, which can be the current month). Membership Term is one year based on your anniversary date.

Start Month

Start Year (yyyy)

Authorization

Our Organization has chosen to join PCHAlliance for the next 12 month period and understand that eligibility and access to member benefits begins upon acceptance by PCHAlliance of our Organization's full payment of dues.

Payment by EFT/ACH, Wire/Bank Transfer or Check is required within 30 days of this application and member benefits will begin upon approval of the application and receipt of payment. An invoice request can be made below.

By signing this form, I confirm that I, the Applicant, warrant that I have all requisite authority for and on behalf of the entity seeking membership, and that the information provided is truthful and accurate. I understand and consent to PCHAlliance's Terms and Conditions which can be viewed here.

By signing this Membership Agreement, my organization, our employees, representatives and agents agree to receive communications via telephone and email from PCHAlliance employees and representatives, and agents who are directly related to my organization's participation in PCHAlliance.

Authorizing Signatures

○ We have read, understand and accept the terms and conditions of PCHAlliance Membership.

Authorized Signatory for Member Organization:

Name

Title

Authorized Signature***

Date (mm/dd/yyyy)

Method of Payment

Select one below (include PO# or attach, if applicable):

○ I am requesting an invoice and will pay by EFT/ACH, Wire/Bank Transfer or Check and require the special instructions below for invoice submission:

○ I hereby authorize HIMSS-PCHA to charge the credit card listed below:

○ Visa ○ MasterCard ○ American Express ○ Discover

Name that appears on the credit card

Card Number

Expiration Date (mm/yy)

Authorized Card Holder Signature***

Submission Instructions

Complete ALL SECTIONS of this Membership Application. Sign*** and Submit Application and Payment (if applicable). Retain a copy for your records.

CLICK HERE TO SUBMIT PDF VIA EMAIL

PCHAlliance Office Use Only

Authorized Signature for PCHAlliance

Title

Date (mm/dd/yyyy)

PCHAlliance is a business unit of HIMSS. www.himss.org

*** **Authorized Signatures**: open this PDF in Adobe Acrobat and sign the document using a digital ID. If you do not have the correct program or have issues with the digital ID, fill out the form, print, sign and fax to:

Attention: HIMSS Finance at (312) 915-9209