SOUTH CAROLINA ASSOCIATION OF HOSPITAL AUXILIARIES
APPLICATION FOR MEMBERSHIP

South Carolina Hospital Association
1000 Center Point Road
Columbia, SC 29210

DATE:_____

The Auxiliary hereby applies for membership in the South Carolina Association of Hospital Auxiliaries,, affiliated with the South Carolina Hospital Association.

NAME OF AUXILIARY: _____
(Hospital)

ADDRESS:_____
(Street Address & Mailing Address)

_____
(City, State. Zip Code)

TELEPHONE:_____ NUMBER OF MEMBERS: _____
(Hospital) (Active and Associated - Not Juniors)

Director of Volunteer Services / Manager / Hospital Representative / Coordinator

TITLE EMPLOYEE WORK PHONE # CP # E-MAIL

_____

_____

_____

AUXILIARY
PRESIDENT: _____

HOME ADDRESS: _____
(complete mailing address)

HOME PHONE:_____ CELL PHONE:_____ E-MAIL_____ TERM EXPIRES _____

AUXILIARY PRESIDENT
VICE-PRESIDENT OR ELECT_____

HOME ADDRESS: _____
(complete mailing address)

HOME PHONE:_____ CELL PHONE:_____ E-MAIL_____ TERM EXPIRES _____

SIGNED:_____ TITLE:_____ DATE_____

SCAHA DUES SCHEDULE:	Less than 25 members	$40.00
	26 up to 50 members	$65.00
	51 to 125 members	$100.00
	126 to 175 members	$150.00
	176 to 225 members	$245.00
	226 and up	$305.00

NOTE: Dues are non-refundable, and are payable on January 1st of each year.

Revised July 22, 2014