



## PERSONAL ASSOCIATE APPLICATION

**PERSONAL ASSOCIATE MEMBERS** enjoy all the privileges of membership: receipt of publications, services, participation on committees, state and district meetings, and special event registrations at reduced member rates.

ALL OTHER PERSONS CONNECTED WITH THE ALLIED HEALTH OR LONG TERM CARE FIELD

**\*\*\* NOT EMPLOYEES OF OR AFFILIATED WITH NON-MEMBER LTC FACILITIES. \*\*\***

IF EMPLOYED, BY WHOM? \_\_\_\_\_

**ANNUAL DUES SUBMITTED (please include) \$150**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
*City* *State* *Zip Code*

Home Telephone: ( ) \_\_\_\_\_

Cell Telephone: ( ) \_\_\_\_\_

Fax: ( ) \_\_\_\_\_

Email: \_\_\_\_\_

Hereby applies for Associate Membership in the Virginia Health Care Association (VHCA) and the Virginia Center for Assisted Living (VCAL), agreeing to comply with all the rules and procedures as stated in VHCA Bylaws and amendments thereto, and to respect high standards of service.

**Endorsed by:** \_\_\_\_\_  
(Personal Associate members must be endorsed by a VHCA/VCAL facility representative)

**Date:** \_\_\_\_\_

(over)

**PAYMENT OPTIONS**

**Enclose a check or complete the following credit card information**

Check\_\_\_ VISA/MC\_\_\_ Card # \_\_\_\_\_

Expiration Date \_\_\_\_\_

Three Digit Card Verification Code (on back of credit card) \_\_\_\_\_

Print Name of Cardholder \_\_\_\_\_

Signature \_\_\_\_\_

Cardholder's Billing Address

\_\_\_\_\_

\_\_\_\_\_

*City* *State* *Zip*

Total Amount Enclosed \$ \_\_\_\_\_

Please submit dues payment along with this application.

Make checks payable and mail to:

**Virginia Health Care Association**  
**2112 West Laburnum Avenue**  
**Suite #206**  
**Richmond, Virginia 23227**  
**Fax: 804-353-3098**