



**VIRGINIA HEALTH CARE ASSOCIATION
VIRGINIA CENTER FOR ASSISTED LIVING
FACILITY MEMBERSHIP APPLICATION**

(PLEASE PRINT)

FACILITY NAME: _____

ADDRESS: _____

TELEPHONE: () _____ FAX () _____

E-MAIL: _____ WEBSITE _____

MANAGEMENT COMPANY: _____

ADMINISTRATOR NAME: _____

TYPE: _____

Proprietary, Chain, Independent Proprietary, Non-Profit, Hospital Affiliated

Licensed Nursing Facility Beds # _____ Nursing Facility State License # _____

Licensed Assisted Living Beds # _____ Assisted Living State License # _____

Annual Dues Submitted (please include)

Signature

Title

Please Print Name

Date

Endorsed By

District

Received by Board Secretary/Treasurer

Acknowledged

Board of Directors Approval

Date

Hereby applies for Facility 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.

(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 annual 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