NHIA
National Home Infusion Association

NURSING PROVIDER MEMBERSHIP APPLICATION

NURSING PROVIDER INFORMATION

*Please type or print clearly. *Indicates a required field.*

Company Name*

Street Address*

City* **State/Province*** **Zip*** **Country**

Telephone* **Fax***

Primary Business Contact* **Job Title***

❑ Check here if address is same as above, if not please add below

❑ Check here if your company is hospital owned

Complete this section if your company has multiple branch locations and or subsidiaries.

This information will allow NHIA to appropriately connect each member to their respective locations.

Please use the supplementary form to add additional branches or subsidiaries.

❑ **BRANCH** ❑ **SUBSIDIARY** **Branch/Sub Name**______________________________

Mailing Address

City **State/Province** **Zip** **Country**

Telephone **Fax**

Branch Manager

SELECT/COMPLETE DESIRED PAYMENT METHOD BELOW:

$ Amount ______________________________

❑ **Enclosed is a check**** (#_________) made payable to NHIA.

❑ **Charge:** ❑ Visa ❑ MasterCard ❑ American Express ❑ Discover

Name on Card

Account Number

Exp. Date Billing Zip-Code CVV

Signature (required)

NURSING PROVIDER MEMBERSHIP DUES

Any corporate entity that supplies services to the home infusion industry by performing in-home nursing support for patients of home infusion providers may qualify for membership. Dues will be assessed according to a progressive schedule based on revenue derived from providing home infusion clinical services.

❑ **Up to $1 million revenue – $800 annual dues**

❑ **Up to $2 million revenue – $1,000 annual dues**

❑ **Over $2 million and up to $5 million revenue – $2,000 annual dues**

❑ **Over $5 million and up to $10 million revenue – $3,000 annual dues**

❑ **Over $10 million revenue – $5,000 annual dues**

Your membership entitles any of the employees you select to receive membership benefits including their own password for the website. You may submit an updated roster to memberservices@nhia.org or by calling 703-549-3740.

Authorized Signature (Required)

By signing this invoice, I affirm that this company is an infusion provider and the Dues Category selected above correctly represents the organization's Net Infusion Sales.

** **Checks must be made payable in U.S. dollars to NHIA. Mail to:**

NHIA c/o United Bank
PO Box 222831
Chantilly, VA 20153-2831

Fax: 888-206-1532

Questions: Call NHIA's Membership Department at 571 814-3755 or email memberservices@nhia.org

Please list additional staff to be added to your NHIA membership.

❑ Dr. ❑ Ms. ❑ Mr. Full Name: ______________________

❑ RPh ❑ PharmD ❑ RN ❑ Other ______________________

Company *(must be same as company on application)*: ______________________

❑ Check here if Company name and contact is the same as listed on application

Job Title: ______________________

Street Address: ______________________

Company Address Only ______________________

City: ________ State: ________ Zip: ________

Telephone: ______________________ Fax: ________

E-Mail: ______________________

Primary Job Function (check one)

❑ Nurse
❑ Billing/Reimbursement – A/R Manager
❑ Case Manager
❑ Consultant
❑ Dietician
❑ Discharge Planner
❑ Educator
❑ Financial Officer
❑ Government
❑ Human Resources Professional
❑ Manager
❑ Operations
❑ Owner/CEO
❑ Physician
❑ Retired
❑ Sales & Marketing Professional
❑ Student
❑ Technology/IT
❑ Trustee/Board of Director
❑ Other

This is the appropriate employee to contact regarding the following NHIA communications or activities:

❑ Legislative/Government Affairs
❑ Sales/Marketing
❑ Day-to-day Operations Manager
❑ Membership
❑ Primary Pharmacy Clinician
❑ Nursing Supervisor

❑ Dr. ❑ Ms. ❑ Mr. Full Name: ______________________

❑ RPh ❑ PharmD ❑ RN ❑ Other ______________________

Company *(must be same as company on application)*: ______________________

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Company Address Only ______________________

City: ________ State: ________ Zip: ________

Telephone: ______________________ Fax: ________

E-Mail: ______________________

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❑ Financial Officer
❑ Government
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❑ Nursing Supervisor

Please make copies of this form to add additional staff.

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Multiple Branch Locations and/or Subsidiaries

Supplemental Form

Complete this form if your company has multiple branch locations and or subsidiaries.

This information will allow NHIA to appropriately connect each member to their respective locations.

☐ Branch ☐ Subsidiary

BRANCH/SUB NAME ____________________

MAILING ADDRESS ____________________

CITY __________ **STATE** __________ **ZIP CODE** __________

PHONE (______)__________ **FAX** (______)__________

BRANCH MANAGER ____________________

☐ Branch ☐ Subsidiary

BRANCH/SUB NAME ____________________

MAILING ADDRESS ____________________

CITY __________ **STATE** __________ **ZIP CODE** __________

PHONE (______)__________ **FAX** (______)__________

BRANCH MANAGER ____________________

☐ Branch ☐ Subsidiary

BRANCH/SUB NAME ____________________

MAILING ADDRESS ____________________

CITY __________ **STATE** __________ **ZIP CODE** __________

PHONE (______)__________ **FAX** (______)__________

BRANCH MANAGER ____________________