ASSOCIATION OF UNIVERSITY PROGRAMS IN HEALTH ADMINISTRATION

Affiliate Member Application

Company/
University:
Program Name
(if appl):
Campus (if appl):

Mailing Address: _____

_____

_____ _____ _____ _____
City State Zip Country

Primary Contact: _____
First Last Honorifics

Title: _____

Phone: _____ Fax: _____

E-Mail: _____ Website: _____

For programs, in what academic setting is your program housed?

- ☐ Allied Health
- ☐ Business/Management
- ☐ Health Professions/Health Sciences Medicine
- ☐ Nursing
- ☐ Public Administration/ Public Services /Public Affairs
- ☐ Public Health
- ☐ Other _____

Name(s) of Degrees Awarded by Program: _____

Number of degrees granted by program (in all settings for which you are applying) in last full academic year.

_____

Does your program/Department/School have any specialty accreditation?

Affiliate Membership qualifies your program for up to four additional faculty to be included. Please provide their contact information below.

Faculty #1: _____
First Last Honorifics

Title: _____

Phone: _____ Fax: _____

E-Mail: _____

Faculty #2: _____
First Last Honorifics

Title: _____

Phone: _____ Fax: _____

E-Mail: _____

Faculty #3: _____
First Last Honorifics

Title: _____

Phone: _____ Fax: _____

E-Mail: _____

Faculty #4: _____
First Last Honorifics

Title: _____

Phone: _____ Fax: _____

E-Mail: _____

Dues
Amount Included: $_____

_____ _____
Name Date

Please mail your application, along with a dues check, to:

AUPHA
Membership Division
1730 M Street NW, Suite 407
Washington, DC 20036