



**ASSOCIATION OF UNIVERSITY PROGRAMS
IN HEALTH ADMINISTRATION**

International Program Membership Application

University: _____

Program Name: _____

Campus (if appl): _____

Mailing Address: _____

City	State	Zip	Country
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Program Director:	First	Last	Honorifics
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Title: _____

Phone: _____ Fax: _____

E-Mail: _____ Website: _____

- Program Level:
- Bachelors
 - Masters
 - Doctoral
 - Executive

- In what academic setting is your program housed?
- Allied Health
 - Business/Management
 - Graduate Studies
 - 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.

