ASSOCIATION OF UNIVERSITY PROGRAMS
IN HEALTH ADMINISTRATION

PROGRAM MEMBERSHIP APPLICATION

University:

Program Name:

Campus (if appl):

Mailing Address: _____

_____

_____ _____ _____
City State Zip

Program Director: _____
First Last Honorifics

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.

What is your regional accreditation?

- ☐ MSA
- ☐ NCA
- ☐ NEASC
- ☐ NWCCU
- ☐ SACS
- ☐ WASC

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

- ☐ AACSB
- ☐ CEPH
- ☐ NASPAA
- ☐ None
- ☐ Other: _____

Do you intend to stand for AUPHA Certification or CAHME Accreditation within the next 8 years? ○ Yes ○ No

Do you wish to participate in the centralized application service, HAMPCAS? ○ Yes ○ No

Membership Type (check one)

- ○ Full Graduate Program
- ○ Associate Graduate Program
- ○ Full Certified Undergraduate Program
- ○ Associate Undergraduate Program

Discounts are available for multiple program memberships. Conatact AUPHA for information.

Dues

Amount Included: $_____

For dues amounts, please see accompanying dues schedule.

Signature

By signing below you confirm that all of the information provided above is accurate. If you have chosen to join as an associate graduate candidate program or associate undergraduate candidate program, your signature below implies that you intend to stand for accreditation or certification. You will be asked to provide a report on your progress toward certification or accreditation annually. Should your program's intentions change at any time, AUPHA should be informed immediately.

_____ _____

Name Date

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

AUPHA
1730 M Street NW
Suite 407
Washington, DC 20036

Faculty List

Please provide contact information for first additional faculty member to add to your membership.

Name: _____

Title: _____

Phone: _____

Email: _____

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