____ **Operator Member** *(free for 2024)*

____ **Institutional Member** *(free for 2024)*

____ **Retired/Affiliate Member** *(free for 2024)*

____ **Students** *(free for 2024)*

____ **Business Partner Sponsorship** *($1000/year – includes 4 attendees per event)*

____ **Business Partner Individual Event Rate** (*$250 per event attendee)*

Please use QR code to submit payment (must have app on device to pay via PayPal)

AHF MICHIGAN CHAPTER

Mail Completed Application and Check to:

Grant Fletcher
Bronson Food & Nutrition Services
601 John Street Box 27
Kalamazoo, MI 49007

Make check payable to: Michigan Chapter AHF
Membership follows the Calendar Year

Calendar Year:

2024

Contact and Facility Information

Name_____ Title _____

Credentials _____ Email Address _____

Company/Facility _____

☐ Acute Care Facility ☐ Long Term Care Facility ☐ Other (please specify) _____

Street Address_____City _____ State _____ ZIP _____

Office Phone _____ Office Fax _____ Cell/Other_____

Food Service: ☐ Self-Operated ☐ Contract Managed by: _____

Please indicate if you are interested in participating in any of the following committees/offices:

☐ Membership Committee ☐ Board of Directors ☐ Education/Program Committee

By signing this application, I attest that I qualify for membership in AHF. I am employed by the facility or health care system where I work and not by a 3rd party contract management company. Contract Employees **do not** qualify for AHF Membership.

Signature:_____Date: _____

Membership Chair Use Only

Date Received _____ Added to the Mailing List _____ Expiration Date_____

ADD Additional Members
Name, Title and Email Address

1)

2)

3)

4)

5)