RENAL HEALTHCARE ASSOCIATION
SUPPORTING DIALYSIS FACILITIES AND PROFESSIONALS

2020-2021 RHA MEMBERSHIP APPLICATION

Membership through June 30, 2021

This application is in accordance with Renal Healthcare Association Bylaws.

Please select one class of membership that best represents your request for membership:

❑ **Active Member** ❑ **Affiliate Member**

Organization/
Company name: _____

Headquarters Address: _____

_____

City, State, Zip: _____

Phone: _____

Fax: _____

Company's Primary Provider Type (check one):

❑ Freestanding Dialysis Provider ❑ Hospital-Based Dialysis Provider ❑ Management Consulting Company
❑ Corporate

Profit Status: ❑ Non profit ❑ For profit

Organization Type: ❑ LDO ❑ MDO ❑ SDO ❑ Independent ❑ Hospital-Based

Approximate # of patients:
Home:_____
In-Center:_____

Number of Facilities:
Freestanding:_____
Hospital-Based:_____

PRIMARY REPRESENTATIVE INFORMATION

Each Active Member must designate one Primary Representative. Only the Primary Representative for an Active Member is eligible to vote and serve on the Renal Healthcare Association Board of Directors.

Name: _____ Job Title: _____

Credentials: _____License Number (CNE/CME):_____

E-mail: _____

ESRD Experience Level: ❑ More than 5 years ❑ 3-5 years ❑ 1-3 years

Specialties/Disciplines: ❑ Pediatrics ❑ General/Internal Medicine ❑ Transplant Medicine ❑ Immunosuppresion
❑ Intensive Care Medicine ❑ Clinical Pharmacology ❑ Perioperative Medicine ❑ Pediatric Nephrology
❑ Kidney Transplantation ❑ Chronic Kidney Disease ❑ Cancer-related kidney diseases ❑ Procedural Nephrology

Address: _____

❑ Same as company information listed above

City, State, Zip: _____

Phone: _____ Fax: _____

Supplying your e-mail address gives RHA permission to communicate with you via e-mail.

Name (print): _____ Signature: _____

Date: _____

ADDITIONAL CONTACTS

$50 per individual

An **Active** or **Affiliate Member Company** may identify unlimited additional contacts as part of their active membership. Please attach names and contact information if you have more than one additional contact.

Additional Contact Information #1

Name: _____ Title: _____

Credentials: _____ License Number (CNE/CME): _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____ E-mail: _____

Additional Contact Information #2

Name: _____ Title: _____

Credentials: _____ License Number (CNE/CME): _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____ E-mail: _____

Additional Contact Information #3

Name: _____ Title: _____

Credentials: _____ License Number (CNE/CME): _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____ E-mail: _____

Additional Contact Information #4

Name: _____ Title: _____

Credentials: _____ License Number (CNE/CME): _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____ E-mail: _____

Supplying your email address gives RHA permission to communicate with you via email.

Please send in ONE application and payment (to include company dues AND additional contact payments)

Membership Categories

Active Member: (through June 30, 2021): Any COMPANY that meets the RHA definition of Provider Company or Management Consulting Company. An Active member company must designate a Primary Representative to represent it. An Active member may have unlimited non-voting Additional Contacts that may participate in RHA activities and benefits.

❑ Active Membership = $350.00 ❑Additional Contacts = $50 x ____ = _____

Affiliate Member: (through June 30, 2021): Any COMPANY involved in the ESRD industry and supportive of the purposes of RHA, and are not eligible for membership as an Active member of RHA. An Affiliate member may have unlimited Additional Contacts that may participate in RHA activities and benefits.

❑ Affiliate Membership = $350.00 ❑Additional Contacts = $50 x ____ =____

Primary Representative: (dues are included with company membership)
An Active Member is represented by an individual who has been designated in writing to be the Primary Representative by the company. A company can only have one Primary Representative at a time. A change in Primary Representative may be made by the company in writing to RHA.

Additional Contact: (dues $50 each through June 30, 2021)
An **Active Member** or **Affiliate Member Company** may identify unlimited Additional Contacts as part of their membership. Additional Contacts are not eligible to vote or be a candidate for, elected to or appointed to the Board or serve as an Officer.

How did you learn about RHA?

- ❑ Colleague (Please name):_____
- ❑ Meeting (Please list):_____
- ❑ Magazine Ad/Editorial (Please list): _____
- ❑ Website: ❑ renalhealthcare.org
  ❑ Other (Please list):
- ❑ Renal Healthcare Association Mailing

PAYMENT INFORMATION

❑ Check is enclosed (payable to RHA) Amount: $ _____

Mail with Payment to: Renal Healthcare Association
19 Mantua Rd.
Mt. Royal, NJ 08061

Credit Card payments may be emailed to admin@renalhealthcare.org

❑ VISA ❑ MasterCard ❑ Amex Amount: $ _____

Credit Card # _____ Exp. Date: _____

Name on Card: _____

Signature: _____

For federal tax purposes, Renal Healthcare Association membership dues may be deductible as a business expense but not as a charitable contribution. Additionally, 35% are not deductible per state and federal lobbying activities as defined by the IRS.

Thank you for your interest in joining RHA! Once your application has been approved and processed, you will receive an email with your membership details, including login information.