



**Washington State Association  
For Healthcare Quality  
Membership Application/Renewal**

**Membership Type** (Please check one)

- Individual – 1 Yr (\$50)
- \*Corporate 1 – 5 members (\$185)

**Today's Date:** \_\_\_\_\_

- Individual – 2 Yr (\$90)
- \*Corporate 6 – 10 members (\$375)

\*For Corporate memberships, please list the primary contact information below and use the Corporate Membership addendum to list additional members from the same company/corporation.

**New**

**Renewal**

**Member Information**

First Name	_____	Last Name	_____
Company	_____	Title	_____
Street	_____	City	_____
State	_____	Zip Code	_____
Telephone	_____	Fax	_____
Email	_____	CPHQ#	_____

What is the name of your organization? \_\_\_\_\_

# of employees? \_\_\_\_\_ # of beds (if applicable)? \_\_\_\_\_

Would you like to be listed in our directory? Yes \_\_\_\_\_ No \_\_\_\_\_

**Organizational/Facility Type (Please Circle):**

General/Acute	Psychiatric	Pediatric	Rehabilitation
Long-term/ SNF	Ambulatory	Home Health	Managed Care Organization
Insurance Co.	Multiple Health System	University/ Teaching	Consulting Service
Military	Veteran's Administration	State	
Other (Please specify)			

**WSAHQ INVOLVEMENT – I WOULD LIKE TO BE CONTACTED:**

<input type="checkbox"/>	Working on the Education/Program Committee (this includes the Annual Conference)
<input type="checkbox"/>	Working on the Membership Committee

**WSAHQ INVOLVEMENT – I WOULD LIKE TO BE CONTACTED:**

	Working on the Nomination Committee
	Writing articles for the Newsletter
	Being an Eastern or Central Washington Regional Representative to the Board of Directors
	Becoming an officer on the Board of Directors
	Joining the National Association for Healthcare Quality (NAHQ)
	Becoming a Certified Professional in Healthcare Quality (CPHQ)

**Educational Background (Circle all that Apply):**

RN	LPN	RHIT	RHIA
MD	MSW	BS/BA Degree	Master's Degree
PhD	Other (please specify)		

**Years of Experience in Healthcare Quality (Circle all that Apply):**

Less than one year	1-2 years	3-5 years	6 – 10 years
11-14 years	More than 15 years		

**Position (Regardless of Title; Please Circle):**

Executive	Administrator	Director	Manager
Supervisor	Coordinator	Analyst	Consultant
Staff Nurse	Physician	Staff Assistant	Staff

**Primary Area of Responsibility (Please Circle):**

QI/QM	RM	UM	Case Management
Medical Records	Nursing	Infection Control	CQI/TQM
Medical Staff/ Medical Affairs	Patient Representative	Organizational Effectiveness	Other (please specify)

**Are you a member of any other professional organizations?** Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list \_\_\_\_\_

## Corporate Membership Addendum

Corporation/Company Name: \_\_\_\_\_

Corporation/Company Primary Contact: \_\_\_\_\_

Date of Membership/Renewal \_\_\_\_\_

**Membership Type:**     Corporate 1 – 5 members (\$185)     Corporate 6 – 10 members (\$375)

Please list additional members below. Each member will receive an email notification with their password; they can then go into the member's only area and complete the rest of their information.

Name	Email Address
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	