Associate Membership Application

Please make any changes to contact information that may already be printed on the application form.

Company ____

Address ____

City, State, ZIP ____

Website ____

Primary Contact ____________________ **Title/Position** ____________________

Email ____________________ **Phone** ____________________

Additional Contact(s):

Name	Title/Position	Email

Mailing address for other contact(s) if different than above.

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Please provide a brief description of your company:

Associate Membership Dues: $500

Dues payment covers membership January through December.

Make checks payable to: Wisconsin Association for Home Health Care, Inc (or WiAHC)

Tax ID #: 45-4583449

563 Carter Court, Suite B ● Kimberly, WI 54136
920-560-5632 ● 920-882-3655 (fax)
WiAHC@badgerbay.co ● www.wiahc.org