

Oklahoma Society for Healthcare Strategy & Market Development

Membership Application

Membership Categories

Type 1 - Regular - Regular membership is available to those individuals who have active responsibility for the management and/or implementation of the marketing, public relations, or development program of a healthcare institution. **Dues: \$50 per year.**

Type 2 - Affiliate - Affiliate membership is available to those individuals who are members of private marketing, public relations or development firms. **Dues: \$200 per year.**

Type 3 - Student - Student membership may be made available to individuals who are actively pursuing a full-time course of study in marketing, public relations or a related discipline and who have demonstrated an interest in a career in healthcare marketing or public relations. **Dues: \$25 per year.**

I am interested in the objectives of the Oklahoma Society for Healthcare Strategy & Market Development, and hereby apply for (check one) **Regular** **Affiliate** **Student** membership to the organization by submitting the following information for consideration by the board of directors:

Name _____

Position/Title _____

Organization _____

Office Mailing Address _____

City _____ State _____ Zip Code _____

Work Phone (This will be your contact number in OSHSMD member directory.) _____

E-mail _____

Hospital/Organization Website _____

Length of Time in Current Position: From _____ To _____
(month/year) (month/year)

Duties: _____

Are you a member of the American Hospital Association's national Society for Healthcare Strategy & Market Development?

Yes No / If Yes, for how long? _____ Years

Prior Positions

Please tell us about positions you held prior to your current one, including other positions you may have held within your current organization, beginning with the most recent. (If applying for student membership, skip to the next section.)

1) Organization _____

Position Title _____

Tenure in Position: From _____ To _____
(month/year) (month/year)

2) Organization _____

Position Title _____

Tenure in Position: From _____ To _____
(month/year) (month/year)

Educational Background

College/University _____ City/State _____

Degree _____ Field _____ Year _____

College/University _____ City/State _____

Degree _____ Field _____ Year _____

I attest to the accuracy of the information contained in this application, and understand that after approval of this application by the OSHSMD board of directors, and receipt of the \$ _____ membership dues, I will become a member of the Oklahoma Society for Healthcare Strategy & Market Development.

Signature _____ Date _____

Payment Options

_____ **Check Enclosed** (Payable to: Oklahoma Hospital Association) Amount: \$ _____

_____ **Credit Card** VISA MasterCard American Express

Account No. _____ Expiration Date: _____

Name as Appears on Card _____

Cardholder Billing Address _____ Zip Code _____

Signature _____

Please mail **application with check payment** to:

Oklahoma Hospital Association
Dept. #96-0298
Oklahoma City, OK 73196-0298

Please mail **application with credit card payment** to:

Oklahoma Hospital Association
4000 Lincoln Blvd
Oklahoma City, OK 73105

If you have any questions, please call the Oklahoma Hospital Association, (405) 427-9537.