HCEA
Healthcare Convention & Exhibitors Association

MEMBERSHIP APPLICATION

Name of Organization _____

Address _____

City _____ State _____ Zip _____

Country _____ Website _____

Primary Contact _____ Title _____

Telephone _____ Fax _____ Email _____

Secondary Contact _____ Title _____

Telephone _____ Fax _____ Email _____

Referred By _____

ASSOCIATION MEMBER
a healthcare association or society, medical conference organizer or an association management company that manages medical associations and societies.

CORPORATE MEMBER
a manufacturer or distributor of products or services used or prescribed by the medical, hospital, dental, nursing, or other allied healthcare professions.

INDUSTRY PARTNER MEMBER
organizations engaged in providing products or services that pertain to healthcare congresses, exhibits or meetings.

Please select the amount of individuals that will be receiving benefits from your company.
Membership dues are based on the amount of individuals receiving benefits from your company.

Number of Individuals Linked to an Organization	Association Annual Dues	Corporate Annual Dues	Industry Partner Annual Dues
☐ 1 Individual	$250	$350	$650
☐ 2 – 5 Individuals	$450	$550	$950
☐ 6 – 9 Individuals	$650	$750	$1,250
☐ 10 + Individuals	$850	$950	$1,450

NOTE: *The HCEA annual membership year is from January 1 through December 31. Dues are prorated at a monthly rate as the membership year progresses. HCEA membership belongs to the organization and not the individual, therefore doesn't transfer when an individual leaves an organization. However, if an individual leaves the organization, HCEA will maintain the individual as a member, extending the membership through the same expiration date and to another individual within the organization*

PAYMENT OPTIONS

☐ Check enclosed ☐ Charge to: ☐ American Express ☐ MasterCard ☐ Visa

Card Number _____ Exp. Date (MM/YY) _____

Name on Card (please print) _____ CVV/Security Code _____

Billing Address _____

Signature _____ Date _____

If accepted into membership, we agree to abide by the bylaws of the Healthcare Convention & Exhibitors Association and to follow its Guidelines for Healthcare Conventions insofar as they pertain to conduct and procedure at healthcare meetings. By signing this application, I give HCEA permission to fax and email company representatives.

Signature of Applicant _____

Title _____ Date _____

For U.S. income tax purposes, membership dues and contributions to this association are deductible as business expenses, not as charitable contributions. (Federal I.D. Number 23-1494789).

To apply for membership, return this completed application to the address shown below.
7918 Jones Branch Drive | Suite 300 | McLean, VA 22102
Phone: 703-935-1961 | Fax: (703) 506-3266 | info@hcea.org | www.hcea.org