NHIA
National Home Infusion Association

# PROVIDER MEMBERSHIP APPLICATION

**Please type or print clearly. *Indicates a required field.**

## COMPANY INFORMATION

Company Name*

Street Address*

City* State/Province* Zip* Country

Telephone* Fax*

Primary Business Contact* Job Title*

❑ *Check here if address is same as above, if not please add below.*

Telephone* Email*

❑ Please check here if your company is hospital owned
# of Licensed Compounding Pharmacy Location _____

Your provider membership entitles any of the employees you select to receive membership benefits including their own password for the website. You may submit a roster at anytime by calling 703-549-3740 or visiting www.nhia.org/roster.

### Select/complete desired payment method below:

❑ Enclosed is a check** (#_____ )made payable to NHIA.

❑ Charge: ❑ Visa ❑ MasterCard
❑ American Express ❑ Discover
$Amount _____

Account Number

Exp. Date Billing Zip-Code

Signature (required)

Name on Card

*** Checks must be made payable in U.S. dollars to NHIA and mailed to: P.O. Box 71223, Philadelphia, PA 19176-6223*

**Mail:** NHIA c/o United Bank
PO Box 222831
Chantilly, VA 20153-2831

**Fax:** 888-206-1532

**Questions:** Call NHIA's Membership Department at 703-549-3740, or email info@nhia.org

Select your organization's net infusion sales from the list below (based upon the following definition: "Net revenue" refers to an organization's total net revenue from infusion and injectable drugs, as well as enteral and parenteral nutrition therapies)—and kindly remit determined dues category:

| Member Net Sales: | Dues Category: |
|---|---|
| ❑ Less than $500,000 | $800 |
| ❑ $500,000 – $999,999 | $1,200 |
| ❑ $1 million – $2.99 million | $1,800 |
| ❑ $3 million – $5.99 million | $2,500 |
| ❑ $6 million – $8.99 million | $4,000 |
| ❑ $9 million – $11.99 million | $5,675 |
| ❑ $12 million – $14.99 million | $6,750 |
| ❑ $15 million – $19.99 million | $9,000 |
| ❑ $20 million – $29.99 million | $12,000 |
| ❑ $30 million – $49.99 million | $18,000 |
| ❑ $50 million – $99.99 million | $27,500 |
| ❑ $100 million – $499.99 million | $65,000 |
| ❑ $500 million – $999.99 million | $100,000 |
| ❑ $1 billion and above | $120,000 |

**Authorized Signature (Required)**
*By signing this invoice I affirm that this company is an infusion provider and the Dues Category selected above correctly represents the organization's Net Infusion Sales.*

NHIA Dues are not deductible as charitable contributions for tax purposes, but may be deductible as a business expense. The percentage of dues used for lobbying by NHIA is not deductible as a business expense. NHIA allots 10% of its dues for lobbying.

## Please list additional staff to be added to your NHIA membership.

❑ Dr. ❑ Ms. ❑ Mr. Full Name: _____

❑ RPh ❑ PharmD ❑ RN ❑ Other _____

Company *(must be same as company on application)*: _____

❑ Check here if Company name and contact is the same as listed on application

Job Title: _____

Street Address: _____

Company Address Only _____

City: State: Zip: _____

Telephone: Fax: _____

E-Mail: _____

**Primary Job Function (check one)**

- ❑ Billing/Reimbursement – A/R Manager
- ❑ Case Manager
- ❑ Consultant
- ❑ Dietician
- ❑ Discharge Planner
- ❑ Educator
- ❑ Financial Officer
- ❑ Government
- ❑ Human Resources Professional
- ❑ Manager
- ❑ Nurse
- ❑ Operations
- ❑ Owner/CEO
- ❑ Pharmacist
- ❑ Pharmacy Technician
- ❑ Physician
- ❑ Retired
- ❑ Sales & Marketing Professional
- ❑ Student
- ❑ Technology/IT
- ❑ Trustee/Board of Director
- ❑ Other

**This is the appropriate employee to contact regarding the following NHIA communications or activities:**

- ❑ Legislative/Government Affairs
- ❑ Sales/Marketing
- ❑ Day-to-day Operations Manager
- ❑ Membership
- ❑ Primary Pharmacy Clinician
- ❑ Nursing Supervisor

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❑ Dr. ❑ Ms. ❑ Mr. Full Name: _____

❑ RPh ❑ PharmD ❑ RN ❑ Other _____

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Job Title: _____

Street Address: _____

Company Address Only _____

City: State: Zip: _____

Telephone: Fax: _____

E-Mail: _____

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*Please make copies of this form to add additional staff.*


# Branch Locations & Subsidiaries

Complete this form if your company has multiple branch locations and or subsidiaries. This information will allow NHIA to appropriately connect each member to their respective locations.

□ Branch □ Subsidiary

**BRANCH/SUB NAME** _____

**MAILING ADDRESS** _____

**CITY** _____ **STATE** _____ **ZIP CODE** _____

**PHONE** (_____)_____ **FAX** (_____)_____

**BRANCH MANAGER** _____

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□ Branch □ Subsidiary

**BRANCH/SUB NAME** _____

**MAILING ADDRESS** _____

**CITY** _____ **STATE** _____ **ZIP CODE** _____

**PHONE** (_____)_____ **FAX** (_____)_____

**BRANCH MANAGER** _____

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□ Branch □ Subsidiary

**BRANCH/SUB NAME** _____

**MAILING ADDRESS** _____

**CITY** _____ **STATE** _____ **ZIP CODE** _____

**PHONE** (_____)_____ **FAX** (_____)_____

**BRANCH MANAGER** _____

**CORPORATE OFFICE USE ONLY**

Date _____ /_____ /_____

Completed By _____ Title _____

Please make copies of this form to add additional locations or subs.