Non-Profit Partner Membership Application

Non-Profit Partner Membership is designed for non-profit associations and professional organizations that share HIMSS' objectives to transform healthcare through the effective and efficient implementation of information technology. Non-Profit Partner Membership is available to qualifying organizations at no cost. The primary contact identified below will receive individual HIMSS member benefits for one year as described on the HIMSS web site at www.himss.org/ASP/individualhome.asp

Qualifying organizations must:

- □ be a not-for-profit.
- □ be a professional or trade society or have an interest or stake in healthcare IT related topics.
- □ have an organization mission similar to HIMSS.
- □ not be in the business of providing or selling healthcare related services.
- □ not be in the business of developing or selling healthcare information technology products.

Non-Profit Partner Information

Name of Non-Profit Partner Organization: _____

Primary Contact: (will receive a one year complimentary HIMSS individual membership)

_____

Primary Contact Title: _____

Mailing Address _____

City _____ State _____ Zip _____ Country _____

Phone _____ Fax _____

Organization Website _____

Email (Primary Contact) _____

Participate In (Please check all.)

□ mHIMSS (Become an Non-Profit Partner member of HIMSS global mobile initiative) □ Medical Banking Project interest

□ *Please check here, if you do not want your organization logo listed on the mHIMSS website on the Non-Profit*

Communities of Profession: □ HIMSS Latino □ Nursing Informatics

□ Physician (You must have MD or DO credentials to join.) □ Management Engineering/Process Improvement

_____(name of organization) meets and understands the criteria for joining HIMSS as an Non-Profit Partner Member and has agreed to join HIMSS as an Non-Profit Partner Member.

_____(name of organization) understands that the individual indicated on this application will serve as representative of the organization and will receive a complimentary individual HIMSS membership. Eligibility to benefits will commence on criteria verification and is subject to annual review and renewal.

_____(print name of person submitting application) understands the criteria for HIMSS Non-Profit Partner Membership and agrees to serve as the primary contact for the organization. As primary contact, you agree to act as the liaison between the Non-Profit Partner member and HIMSS staff for all membership processing.

_____Primary Contact Signature

_____Today's date

Submit application or questions to:
Regional Affairs
O: 703-562-8819
F: 703-562-8801

Regular Mail
HIMSS
Attn: Jessica Martin
4300 Wilson Blvd.
Suite 250
Arlington, VA 22203

Email:
jmartin@himss.org