

# AHE Student Membership Application

Type:  Join  Renewal

## CONTACT INFORMATION

Prefix: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Last Name: \_\_\_\_\_

Gender: Male:  Female:

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

## SCHOOL

Name: \_\_\_\_\_

Area of Study: \_\_\_\_\_

Address: \_\_\_\_\_

City, ST, Zip: \_\_\_\_\_

Email: \_\_\_\_\_

## Work

Name: \_\_\_\_\_

Position: \_\_\_\_\_

Address: \_\_\_\_\_

City, ST, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Mobile: \_\_\_\_\_

When applying for or renewing student membership, please enclose with your application, transcripts certifying you are a full-time student at a college, pursuing a degree (12+ credit hours for undergraduate, 9+ credit hours for graduate).

**Student (STU) \$25** – Student Membership with AHE shall be available to full time college students taking course work related to any discipline represented by AHE. Students must not currently be employed in the healthcare field.

**TOTAL AMOUNT DUE:** \_\_\_\_\_

Payments must be included with all Membership Applications. To process credit card payments, please include your signature on the signature line below.

Mail: Check (made payable to AHE) with application

AHE/AHA  
Attn: Professional Membership Groups  
P.O. Box 75315  
Chicago, IL 60675-5315

Type:  VISA  MasterCard  American Express

Credit Card Number: \_\_\_\_\_

Expiration: \_\_\_\_/\_\_\_\_

Name on Card: \_\_\_\_\_

Signature: \_\_\_\_\_

