AHA Membership Form ____ Facility Member

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Facility Name:____

Facility Contact :________________________Phone:____________________

Mailing Address:____

City / State:____________________________________ Zip:_______________

Email: ____

Website: ____

List E-newsletter recipients / Name and email address / Limit of 5:

Name:________________________________Email: ________________________________

Name:________________________________Email: ________________________________

Name:________________________________Email: ________________________________

Name:________________________________Email: ________________________________

Name:________________________________Email: ________________________________

List the facility on AHA's website under "Find a Facility"? Yes/No

Payment method: Credit card / Type: Mastercard / Amex / Visa / Discover

Number: ____________________________________ ***Exp Date:*** ____________________

Check (make checks payable to AHA) #____

******Memberships will require renewal one year from the date of the application******

www. Americanhippotherapyassociation.org