



**AHA Membership Form**

**Individual Member**

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

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

City / State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

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

*Payment method: Credit card / CC type: Mastercard / Amex / Visa / Discover*

*Number: \_\_\_\_\_ Exp Date: \_\_\_\_\_*

*Check (make checks payable to AHA)*

*Mail to: AHA, PO Box 2014 Ft Collins, CO 80522*

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

[www.Americanhippotherapyassociation.org](http://www.Americanhippotherapyassociation.org)