HEALTH CARE ASSOCIATION of MICHIGAN
Membership Application

Facility Information

Facility Name — Bureau of Community Health Systems ID Number

Address

City/Zip Code — County

Administrator — E-mail

Phone — Fax

Web Site

Number of Beds

Please provide a copy of your most recent LC-180

Licensed Beds ____________
Unavailable Beds ____________
Total Beds Operating ____________

Special Beds

As included in bed counts

Alzheimer's Beds ____________
Hospice Beds ____________
Ventilator Beds ____________

Facility Type

Please select one

Proprietary ☐ Non Profit ☐
County ☐ HLTCU ☐

Corporate /Owner Information

Corporation/Owner Name — Number of facilities in Michigan

Address

City/State/Zip Code

President/CEO — E-mail

Phone — Fax

Regional Contact — E-mail

Address

City/State/Zip Code

Phone — Fax

Acknowledgement of Terms & Conditions of Membership

By signing this document, it is acknowledged that an authorized party has read, and the facility agrees to, the stated terms and conditions.

Signature — Date