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