MEMBERSHIP APPLICATION

Please Complete the Following:

Primary Contact/Title ______________________________
Company Name ______________________________
Street Address ______________________________
City/State/Zip ______________________________
Telephone ______________ Fax ______________
Email ______________ Web Site ______________

Network Type:

Acupuncture	Device Benefit Mgmt	Physical Therapy
Behavioral Health	Hearing	Radiology
Complementary/Chiropractic	Massage Therapy	Technology
CVO	Pharmacy Benefit Mgmt	Vision
Dental		Other ______________

Covered States ______________________________

Membership Type:

Student Professional Corporate

Corporate Members are entitled to three additional memberships. If appropriate, please complete the following:

Name/Title ______________________________
Street Address ______________________________
City/State/Zip ______________________________
Telephone/Fax ______________________________
Email ______________________________

Name/Title ______________________________
Street Address ______________________________
City/State/Zip ______________________________
Telephone/Fax ______________________________
Email ______________________________

Name/Title ______________________________
Street Address ______________________________
City/State/Zip ______________________________
Telephone/Fax ______________________________
Email ______________________________

Mail application along with your check to:

NASHO
222 South First Street, Suite 303
Louisville, KY 40202