

**Connecticut Association for Healthcare Quality
Membership Renewal Application**

**TO FACILITATE ELECTRONIC INFORMATION TRANSMISSION, PLEASE BE SURE TO
INCLUDE AN E-MAIL ADDRESS**

Please complete all applicable areas:

New Member **Renewal**

Name: _____ Title: _____

Organization Name: _____

Organization Mailing Address: _____

City, State, Zip: _____

Telephone (W): _____ (H): _____ Fax: _____

E-Mail: _____

NAHQ Member **Yes** **No**

CPHQ **Yes** **No**

Primary Area of Responsibility (check all that apply)

Type of Organization

UM/Case Management

Infection Control

Acute care

Home Care

Risk Management

Home Services

Subacute

Consulting

Patient Safety

Quality Management

Rehabilitation

HMO/ Insurance

Regulatory Compliance

ECF/SNF

Self Employed

Corporate Compliance

Behavioral Health

Other _____

Other _____

Individual Membership \$55.00

Organizational Membership \$110.00 – 3 applications from the same institution
(Please submit together)

Check Amount: _____ Payment Check Number: _____

Who is funding your membership? Employer Self

Please make check payable to **CTAHQ** and mail to:

Beth Carling

61 Thistle Lane

Middletown, CT 06457