

# UTAH HEALTH CARE ASSOCIATION

Representing Utah's *Quality* Leaders in the Long Term Care Industry

\_\_\_\_\_ Date: \_\_\_\_\_

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

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

\_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

\_\_\_\_\_

Owner: \_\_\_\_\_

Administrator: \_\_\_\_\_

License Number: \_\_\_\_\_

Director of Nursing: \_\_\_\_\_

Number of Licensed Beds: \_\_\_\_\_

\_\_\_\_\_

Membership dues are based on the number of licensed beds per facility. The dues structure is currently \$73.60 per bed, per year (\$53.00 state chapter portion and \$20.60 American Health Care Association portion). Dues may be paid either annually or monthly. Remittance for dues payments should be mailed to:

Utah Health Care Association  
2180 S. 1300 E, Suite 445  
Salt Lake City, UT 84106

- ◆ I agree to comply with all rules and standards established by and for the members of the Utah Health Care Association (UHCA).
- ◆ I agree to reimburse UHCA for all dues and fees owed by my organization per the payment schedule outlined in the UHCA by laws.
- ◆ If, in the event, that my organization terminates membership in the UHCA, payment in full will be made for all dues and services rendered up to, and including the date that the written letter of notification is received by UHCA.

\_\_\_\_\_ Title  
*Authorized Signature*

*An Affiliate of the American Health Care Association*