



Membership Application Form

The membership fees are based on the bed size of the facility at the following rates:

Table with 3 columns: Category, Bed Size of Facility, Fee. Rows include Associate members / 0 beds (\$140), 1-99 beds (\$150), 100-199 beds (\$300), 200-399 beds (\$500), 400-599 beds (\$700), 600-799 beds (\$800), and 800 beds and over (\$900).

Proper Name of Auxiliary _____

Hospital Name: _____

Hospital address: _____

City: _____ Province: _____ Postal: _____

Bed Size: _____ Type _____ (Acute, Rehab., etc)

President of Auxiliary: _____

Address: _____

City: _____ Province: _____ Postal: _____

Telephone: () _____ Fax: () _____ Email: _____

Secretary of Auxiliary: _____

Address: _____

City: _____ Province: _____ Postal: _____

Telephone: () _____ Fax: () _____ Email: _____

Treasurer of Auxiliary: _____

Address: _____

City: _____ Province: _____ Postal: _____

Telephone: () _____ Fax: () _____ Email: _____

Date Organization Formed: _____

Month of Annual Meeting: _____

Total Members: _____ Active Members: _____ Inactive Members: _____

Student Program: _____

Membership Fee: _____

Does Your Organization have Representation on your Hospital's Board Yes No

Is Your Organization Incorporated Yes No

Is your Organization a Registered Charity Yes No

Please Complete this form and mail with your payment to:
HAAO, 200 Front Street, Suite 2800, Toronto, On M5V 3L1