Membership Application Form

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

Category	Bed Size of Facility	Fee
1	0 – 99 beds	$225
2	100 – 199 beds	$375
3	200 – 399 beds	$575
4	400 – 599 beds	$775
5	600 beds and over	$875

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: _____

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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