HOSPITAL/SYSTEM MEMBERSHIP APPLICATION

HOSPITAL ASSOCIATION of Southern California

California Hospital Association

ORGANIZATION INFORMATION

_____ *Organization type:* *System* ☐ *Hospital* ☐

Organization name

_____

Street address, city, state and zip

FOR HOSPITAL APPLICANTS

Ownership type: ☐ *Investor owned* ☐ *Not-for-profit* ☐ *City* ☐ *County* ☐ *District* ☐ *University of California* ☐ *State* ☐ *Federal*

If hospital, license category: ☐ *General acute care* ☐ *Acute psychiatric hospital*

Principal service type: ☐ *General medical/surgical* ☐ *Long-term acute care* ☐ *Pediatric* ☐ *Physical rehabilitation* ☐ *Psychiatric* ☐ *Other*

Under construction: ☐ *Yes* ☐ *No* *Opening date:* _____

EXECUTIVE TEAM INFORMATION

Please provide the information below for the top executives in your organization. The information provided (except for phone and email) is published in our online member directory.

JOB ROLE	NAME	TITLE	PHONE	EMAIL
President/CEO				
Assistant to CEO				
On-Site Administrator *(For hospital applicants only and if different from CEO)*				
COO				
CFO				
Human Resources Executive				
Government Relations Executive				

**If a system applicant, please attach a list of all main hospital licensed holders with CEO information (hospital name and CEO name, title, phone and email).*

SIGNATURE

_____ _____

CEO signature *Date*

Please submit a photo of CEO and the organization's logo (high quality, 300 dpi or higher) for publication in the online member directory.