IFHIMA

International Federation of
Health Information Management Associations

A non-governmental organization affiliated with the World Health Organization (WHO)

19TH IFHIMA INTERNATIONAL CONGRESS
18-21 NOVEMBER 2019 | DUBAI
EMPOWERING HIM PROFESSIONALS THROUGH A GLOBAL VOICE

Membership Application Form – 2019

PLEASE INDICATE MEMBERSHIP TYPE

O **Associate Membership** ☐ ***New Application*** ☐ ***Renewal Application***

An individual working in the field of health information management **Annual dues: $35.00**

O **National Membership** ☐ ***New Application*** ☐ ***Renewal Application***

IMPORTANT NOTE: National Membership of IFHIMA is reserved for ONE national organization in each country which is representative of the national activities within the field of health information management/health records and the purposes of this organization must be compatible with those of IFHIMA. **Annual dues: Please refer to Page 3**

PLEASE ALSO COMPLETE & SUBMIT PAGE 3 OF THIS APPLICATION

O **Corporate Membership** ☐ ***New Application*** ☐ ***Renewal Application***

Any institution, company, hospital or other organization working in the healthcare field.

PLEASE ALSO COMPLETE & SUBMIT PAGE 4 OF THIS APPLICATION **Annual dues: $1500 for a three year period.**

O **Educational Institute Membership** ☐ ***New Application*** ☐ ***Renewal Application***

Any educational institution providing formal education in Health Records/Health Information Management. The educational institution is recognized by the local or national Health Information Management Association and meets any nationally required educational accreditation standards. Please see required signed declaration, on Page 4 of this document.

PLEASE ALSO COMPLETE & SUBMIT PAGE 5 OF THIS APPLICATION **Annual dues: $1500 for a three year period.**

Name of Member/Contact Person:

Title	First Name	Last Name
Street Address:		
City:	**State/Province/Region:**	**Postal Code:**
Country:		
Email address:		**Telephone and Facsimile:**

WHO Region

O Americas O Europe and North Asia O Eastern Mediterranean

O Africa O Southeast Asia O Western Pacific

Have you previously been a member of IFHIMA? O YES O NO

Payment Information

Please ✓ the appropriate boxes and complete the requested information. All payments must be made in USD$.

Total Amount to be Paid in USD$:

Payments to be made to: JPMorgan Chase Bank, N. A.

☐ **SWIFT CODE: CHASUS33 ROUTING: 0210-00021 ACCOUNT: 17964792**

☐ **A cheque or bank draft in USD$ is enclosed for the total amount shown above, made payable to "The International Federation of Health Information Management Associations"**

☐ **VISA** ☐ **MasterCard** ☐ **American Express**

Card Number:	**Expiration:**	**Total Amount (USD):**
Signature:	**Date:**	

Please forward this application form, remittance, and membership documentation to:

International Federation of Health Information Management Associations (IFHIMA)
ATTENTION: AHIMA ACCOUNTING DEPARTMENT
233 N MICHGAN 21ST FLOOR
CHICAGO IL 60601
United States of America
IFHIMA@AHIMA.ORG
For more general information about joining IFHIMA visit our web site at www.ifhima.org

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For IFHIMA Office Use Only

Date remittance received: ____________________ Cheque/Bank Draft No.: ____________________

IFHIMA Receipt No.: ____________________ Credit Card Authorization: ____________________

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Application Form for NEW NATIONAL Membership 2019

On behalf of the association named below I herewith apply for National Membership of IFHIMA. I confirm that the association is governed by a constitution and that the officers serving on the managing body of the association are democratically elected by members who pay subscriptions.

Name:
Designation:
Name of National Member Association:
Date:

1. *Please complete and return this form with a copy of the current constitution and a list of elected officers showing their terms of office to Lorraine Nicholson, IFHIMA Membership Chair, at l.nicholson@zen.co.uk*
2. *When you receive notification that the application is approved by the IFHIMA Board, you will receive an invoice for the necessary dues payment. Please pass the attached invoice to the finance department in your organisation for immediate payment – details of payment methods are shown on the invoice.*

National Membership - Annual Dues Payments

Annual dues are calculated on the number of members at the beginning of the year in which the dues are assessed. Please ensure accuracy in reporting the number of members.

No. of Members	Dues	Tick √ as appropriate	Number of Members
1 – 50 members	$50		
51 – 100 members	$100		
101 – 150 members	$125		
151 – 250 members	$150		
251 – 500 members	$325		
501 – 1000 members	$450		
1001 – 2500 members	$700		
2501 – 10,000 members	$1250		
10,001 – 25,000 members	$2000		
>25,000 members	$7000		

IMPORTANT NOTE: National Membership of IFHIMA is reserved for ONE national organization in each country which is representative of the national activities within the field of health information management/health records and the purposes of this organization must be compatible with those of IFHIMA.

Nominated Contact:	
Name of Association:	
Street Address:	**City/State/Province/Postal Code/Country:**
Email address:	
Telephone No:	**Fax No:**

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Application Form for NEW CORPORATE Membership 2019

1. *Please complete and return this form to Ms. Lorraine Nicholson, IFHIMA Membership Chair, at l.nicholson@zen.co.uk*
2. *When you receive notification that the application is approved by the IFHIMA Board, you will receive an invoice for the necessary dues payment. Please then pass this invoice to the finance department in your organisation for immediate payment – details of payment methods will be shown on the invoice.*

PLEASE NOTE:	**The signee below validates and confirms that the company, hospital, institution or other organization indicated below, is recognized by their nation as working within the field of healthcare.**
Name of Company, Hospital, Institution or Other Organization:	
Name of Signatory:	
Designation of Signatory:	
Street Address: City/ State/Province/postal Code/Country	
E-Mail Address:	
Telephone No:	**Fax No:**
Date:	

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Application Form for NEW EDUCATIONAL INSTITUTE Membership 2019

On behalf of the association named below, I herewith apply for Educational Institute Membership of IFHIMA. I confirm that the institute meets nationally required accreditation standards, and is recognized by the local or national Health Information Management Association.

3. *Please complete and return this form to Ms. Lorraine Nicholson, IFHIMA Membership Chair, at l.nicholson@zen.co.uk*
4. *When you receive notification that the application is approved by the IFHIMA Board, you will receive an invoice for the necessary dues payment. Please then pass this invoice to the finance department in your organisation for immediate payment – details of payment methods will be shown on the invoice.*

PLEASE NOTE: **The Educational Institute named on this application form MUST meet any and all nationally required accreditation standards that exist for HIM program delivery. IFHIMA must be notified of any changes to status by the accrediting/certifying body, related to the HIM program offered by the Educational Institute below.**	
Name of Educational Institute Association:	
Name of Signatory:	
Designation of Signatory:	
Street Address: City/ State/Province/postal Code/Country:	
E-Mail Address:	
Telephone No:	**Fax No:**
Date:	