

**ILLINOIS HOSPITAL ASSOCIATION
APPLICATION FOR PLATINUM PARTNER**

Date _____

This organization hereby applies to be a Platinum Partner in the Illinois Hospital Association:

\$10,000 Platinum Partner Fee _____ Total Remittance Enclosed

Name of Organization _____

Street Address _____

City _____ State _____ Zip Code _____

Telephone (____) _____ Fax (____) _____

E-Mail _____

Person to whom mail should be directed _____

Title _____

Mailing address if other than above _____

Type or purpose of organization _____

Please include information on services offered, and list of health care organizations serviced. (Enclose brochure, etc., if available.)

Please review the information below:

- I understand that receipt of my check and application does not ensure acceptance and that this application to become a Platinum Partner is pending approval by the Illinois Hospital Association. Furthermore, I understand that my check will be returned if for any reason Platinum Partner status is not granted.
- Platinum Partners may not use the IHA logo, name, or designation of being a Platinum Partner in a way that represents or implies endorsement by the Association.

I hereby agree to the above conditions.

Signed _____

Title _____

Please return this application with specified remittance to:

Illinois Hospital Association
37092 Eagle Way
Chicago, IL 60678-1370