COMMUNITY FOR ConnectedHEALTH
A HIMSS-Cisco Users Group

# CORPORATE PARTNER APPLICATION

Date_____/_____/_____

## Corporate Information

Company | Company Website

Company Address

City | State | Zip Code | Country

Phone ( ) | Fax ( )

## Primary Contact

❑ Mr. ❑ Ms. ❑ Mrs. ❑ Dr.

First Name | Middle Initial | Last Name

Title

Mailing Address *(if different than above)*

City | State | Zip Code | Country

Phone ( ) | E-mail Address

**Professional Level** *Please choose one that best describes your level of responsibility.*

❑ CEO ❑ COO ❑ CFO ❑ CIO ❑ Vice President ❑ Senior Staff/Manager ❑ Other Senior Manager
❑ Department Director/Head ❑ Marketing ❑ Other ________________________________

## Cisco's Community for Connected Health Corporate Partner Levels and Dues

**Cisco's Community for Connected Health Corporate Partner (members)**

❑ Revenues under $10,000,000 Fee: $1500
❑ Revenues over $10,000,000 Fee: $2500

**Cisco's Community for Connected Health Corporate Partner (non-members)**

❑ Revenues under $10,000,000 Fee: $2000 (includes 2 Cisco CCH/HIMSS memberships)
❑ Revenues over $10,000,000 Fee: $3000 (includes 2 Cisco CCH/HIMSS memberships)

## Payment

Annual dues in the amount of $________ are enclosed. I understand that HIMSS may deposit the enclosed dues pending consideration of this application. In the event the application is not approved, HIMSS will promptly refund my remittance.

**Total amount enclosed: $**______________

❑ Check Enclosed ❑ Visa ❑ Mastercard ❑ American Express ❑ Discover

Card No ________________________________ Expiration Date ______/______

Cardholder's signature

Name on Credit Card (please print)

Make checks or money orders payable to HIMSS.

Mail or fax to: HIMSS Membership • 6901 Eagle Way • Chicago, IL 60678-1690 • fax: 312-915-9209

**Application may be faxed when paying by credit card.** Tax ID#: 36-3906745

## Authorization

*Please complete, then print and fax this form to: 312-915-9209.*

________________________ (name of firm) has agreed to join Cisco's Community for Connected Health Corporate Partner program for the 12 month period beginning ____________(month), _________(year).

________________________ (name of firm) understands that eligibility and access to member benefits begin upon receipt of full payment. If payment is not sent with application, we authorize HIMSS to invoice our firm. We agree to pay full membership dues within 30 days and understand that we will not be eligible for benefits until our full payment is received.

Authorized Signature______________________________________ Date _____/_____/_____

HIMSS is pleased to collaborate with healthcare IT organizations to create focused communities that help member's do their jobs better. HIMSS' participation in the Users Group Alliance Program does not constitute an official endorsement of any entity and the information supplied via any users group does not state or reflect the opinion of HIMSS. User group programming and content is directed by an independent member-based advisory committee and executed by HIMSS staff.

*Rev. 8/09*