

Illinois School Health Association
P.O. Box 208 Bristol, IL 60512
WWW.ISHAWEB.INFO

Personal

Name: _____

Permanent Address: _____

Phone: Home () _____ Work () _____

Email Address: _____ FAX: () _____

Employer: _____

Business/School Address: _____

City: _____

State: _____

Zip Code: _____

Type of Membership

New Member: _____ Renewal: _____

Professional (1 year-\$50.00): _____

Professional (3 years-\$135.00): _____

Retired (1 year-\$25.00): _____

Student (1 year-\$25.00): _____

Organization (1 year-\$50.00): _____

Area of Professional Responsibility School Nurse: _____ Health Educator: _____

Student/Intern: _____ Other: _____ Elementary: _____ Secondary: _____

College: _____ Public Health: _____

Membership Information Membership runs from March to March. Expiration date will appear on mailing label.

Affiliate Membership Are you a current member of ASHA? Yes: _____ No: _____

If not, would you like an ASHA membership application? Yes: _____ No: _____

Verification of Student Status *I certify that the above named student is currently enrolled in a minimum of 9 credit hours per semester of undergraduate or graduate study courses.*

Signature of Professor/Academic Advisor:
