WESTERN HEALTHCARE ALLIANCE

Membership Application

715 Horizon Drive, Suite 485
Grand Junction, CO 81506
970.245.8138

Facility Information

Name of Healthcare Organization: _____

DBA (if different): _____

Physical Address: _____

Mailing Address: _____

City, State, Zip: _____

Phone: _____

Website: _____

Number of Licensed Beds: _____ Current FTEs: _____

Critical Access Hospital Designation: ☐ Yes ☐ No

Class (acute care, etc.): _____

System Affiliations: _____

GPO: _____

Dues (see attached schedule): $ _____

We Designate (name) to Attend WHA Board Meetings: _____

Contact Information

Chief Executive Officer

Name: _____

Title: _____

Phone: _____

Email: _____

Executive Assistant Name: _____

Phone: _____

Email: _____

Chief Financial Officer

Name: _____

Title: _____

Phone: _____

Email: _____

Executive Assistant Name: _____

Phone: _____

Email: _____

WESTERN HEALTHCARE ALLIANCE

Designated Contact with WHA (if different from CEO)

Name: _____

Title: _____

Phone: _____

Email: _____

Executive Assistant Name: _____

Phone: _____

Email: _____

Department Leader Contacts

Chief Medical Officer

Title: _____

Name: _____

Phone: _____

Email: _____

Chief Nursing Officer

Title: _____

Name: _____

Phone: _____

Email: _____

Communication & Marketing

Title: _____

Name: _____

Phone: _____

Email: _____

Compliance

Title: _____

Name: _____

Phone: _____

Email: _____

WESTERN HEALTHCARE ALLIANCE

Emergency Department

Title: _____

Name: _____

Phone: _____

Email: _____

Health Information Management/Medical Records

Title: _____

Name: _____

Phone: _____

Email: _____

Hospital Board Chair

Title: _____

Name: _____

Phone: _____

Email: _____

Human Resources

Title: _____

Name: _____

Phone: _____

Email: _____

Infection Control Director

Title: _____

Name: _____

Phone: _____

Email: _____

Information Technology

Title: _____

Name: _____

Phone: _____

Email: _____

WESTERN HEALTHCARE ALLIANCE

Laboratory

Title: _____

Name: _____

Phone: _____

Email: _____

Materials Management

Title: _____

Name: _____

Phone: _____

Email: _____

Practice Administrator

Title: _____

Name: _____

Phone: _____

Email: _____

Quality Improvement/Risk Management

Title: _____

Name: _____

Phone: _____

Email: _____

Radiology

Title: _____

Name: _____

Phone: _____

Email: _____

Rehabilitation

Title: _____

Name: _____

Phone: _____

Email: _____

WESTERN HEALTHCARE ALLIANCE

Revenue Cycle/Business Office

Title: _____

Name: _____

Phone: _____

Email _____

Authorized Signature

Signature: _____

Name: _____

Title: _____

Date: _____