



Company Membership Application

Company Memberships – Includes Hospital and Health Systems, Medical Clinic/Group Practice, Physician Groups, Hospitalist Organization, HMO/PPO/Managed Care Organizations, Health Insurance Plan Organizations, Medicaid Plan Organizations, Medicare Advantage Plan Organizations, Employer Groups, Home Health Care Agencies (Freestanding, National, Regional), Hospice/Palliative Care Organizations, Skilled Nursing Facilities, Long-Term Care, Companies, ReHab Companies.*

*The Alliance has the right to qualify individuals linked to Company Membership. For example: *Outside of the company's employment* of Consultants, CPAs/CPA Firms, Attorneys/Law Firms, Suppliers, or Manufacturers will not be considered under a Company Roster member that can link to member-only access of the website.

- Company Membership yearly fee is \$750.00 (up to 12 members) in **Remington's Alliance For Integrated Value-Driven Healthcare** and is effective in the month payment is received and continues for one year.
- Membership dues are not transferable, refundable, or prorated.
- The application review process requires 3-5 business days.
- The application form should not be submitted with any blank fields. Failure to complete may prolong the application approval process.

Company Information

Company Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Company Website/URL: _____

Company Status: Publicly Held Privately Held Non-profit

Please return completed form to **Remington's Alliance For Integrated Value-Driven Healthcare**

Fax to: 949-715-1797

Mail to: Remington Report, Inc., c/o Alliance Membership, 30100 Town Center Drive, Ste 421, Laguna Niguel, CA 92677

Questions: Phone: 949-715-1757



Company Membership Application

Company Information (continued)

Type Of Company: (Select one that applies the most).

- Home Care Agency Affiliated/Owned By Home System
- Home Care Agency/Hospital Owned Or Affiliated
- Free Standing/Home Care Agency
- Medical Clinic/Group Practice/Physician Group
- Physician (solo)
- Hospitalist Organizations
- HMO/PPO/Managed Care Organizations
- Employer Groups
- Hospice/Palliative Care Organizations
- Skilled Nursing Facilities
- Long-Term Care Organizations
- ReHab Companies
- Other: _____

Geographic Regions Served:

- National
- Regional
- Local

Agency Size:

- < \$4.9 Million
- \$5 Million – \$9.9 Million
- > \$10 Million

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Company Membership Application

Company Roster

Up to 12 additional individuals* (Primary Contact not included in this number) can be linked to a member company to receive membership services as defined under the "Membership Value Benefits" of The Alliance. If you need to change titles we designated on the form, cross out and replace. Identified individuals will have access to the members-only portion of our Web site.

Download this form and fax to: 949-715-1797. Mailing address at bottom of form. Please print. **All e-mail addresses must be the e-mail address of the actual individual receiving the Alliance membership.**

Primary Contact – The primary contact is the individual from your company designated to receive official Alliance correspondence such as updates to rosters and invoices. This individual does not receive a membership number.

Name: _____ Title: _____

Phone: _____ E-Mail: _____

Address (if different from company): _____

Management Team

President/CEO

Name: _____ Title: _____

Phone: _____ E-Mail: _____

Address (if different from company): _____

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Company Membership Application

Company Roster

COO

Name: _____ Title: _____

Phone: _____ E-Mail: _____

Address (if different from company): _____

CFO

Name: _____ Title: _____

Phone: _____ E-Mail: _____

Address (if different from company): _____

CIO/Director Information Systems

Name: _____ Title: _____

Phone: _____ E-Mail: _____

Address (if different from company): _____

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Company Membership Application

Company Roster

Administrator/Executive Director

Name: _____ Title: _____

Phone: _____ E-Mail: _____

Address (if different from company): _____

Medical Director

Name: _____ Title: _____

Phone: _____ E-Mail: _____

Address (if different from company): _____

Director – Post Acute Services/VP Strategic Planning

Name: _____ Title: _____

Phone: _____ E-Mail: _____

Address (if different from company): _____

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Company Membership Application

Company Roster

VP/Manager/Director Clinical Services

Name: _____ Title: _____

Phone: _____ E-Mail: _____

Address (if different from company): _____

VP/Manager – Quality And Patient Safety

Name: _____ Title: _____

Phone: _____ E-Mail: _____

Address (if different from company): _____

Director – Sales/Marketing Development

Name: _____ Title: _____

Phone: _____ E-Mail: _____

Address (if different from company): _____

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Additional Company Roster

Name: _____ Title: _____

Phone: _____ E-Mail: _____

Address (if different from company): _____

Name: _____ Title: _____

Phone: _____ E-Mail: _____

Address (if different from company): _____

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Conditions Of Membership

- Alliance members receive a host of resources as defined under the "Membership Benefit Values" of The Alliance.
- Membership fees include the maximum of up to 12 qualified individuals.
- Membership dues are not transferable, refundable, or prorated. The Alliance has the right to qualify individuals linked to Company Membership.
- Alliance members are prohibited from providing membership number to any non-member. Any illegal use can result in termination of services. No refund will apply.
- All information on the Members only section is copyrighted and cannot be duplicated, electronically transferred or posted to website without permission from the Alliance.
- For discounted related benefits, an Alliance member must be present to receive the discount.
- Membership in **Remington's Alliance For Integrated Value-Driven Healthcare** is effective in the month payment is received and continues for one year. If there is a change in a roster member, that member is under the original payment date.
- One Year Annual Company Membership Fee to **Remington's Alliance For Integrated Value-Driven Healthcare**
Annual Fee: \$750.00 (Up to 12 Members)

I certify that the information I have provided is complete and accurate to my knowledge, and I agree to abide by membership rules for **Remington's Alliance For Integrated Value-Driven Healthcare**.

Name: _____ Date: _____

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Method Of Payment

The application review process requires three to five business days. Credit card payments will receive an electronic receipt issued by the bank. The Alliance does not accept purchase orders. If paying by credit card – please include that information below.

Payment Type: Visa Master Card American Express Check

Credit Card Number: _____

Exp Date: _____

Name On Credit Card: _____

Billing Address Of Credit Card: _____

City: _____ State: _____ Zip: _____

Email Address to Send Electronic Receipt: _____

If Paying by check, make check payable to: The Remington Report, Inc.
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