



2008 Membership Application

Please indicate your membership type:

<u>Health Industry Company</u> Any firm that develops, manufactures, markets or delivers healthcare products or services. <i>Examples:</i> pharmaceutical, medical device, research firm, hospital, etc.		<u>Health Industry Partner</u> Any organization that provides support service to health industry companies	
<input type="checkbox"/> Revenue less than \$5M	\$300	<input type="checkbox"/> Individual (sole-proprietor)	\$150
<input type="checkbox"/> Revenue between \$5M - \$10M	\$1,000	<input type="checkbox"/> 2 - 10 Employees	\$300
<input type="checkbox"/> Revenue between \$10M - \$50M	\$2,500	<input type="checkbox"/> 10-50 Employees	\$1,000
<input type="checkbox"/> Revenue between \$50M-\$100M	\$5,000	<input type="checkbox"/> Over 50 Employees	\$2,500
<input type="checkbox"/> Revenue above \$100M	\$10,000		
<input type="checkbox"/> Leadership Members	\$25,000	<u>University</u>	
		<input type="checkbox"/> Major Research University	\$5,000
		<input type="checkbox"/> Other	\$1,000

Membership Information

Payment Preference

Organization: _____

Web Site: _____

Address: _____

City, ST, Zip: _____

Phone: _____ Fax: _____

Primary Contact: _____

Title: _____

E-mail: _____

Additional Contacts (Name, Title) and E-mail addresses:

1. _____

2. _____

Company description: _____

Credit card (VISA, MasterCard)

Name on card: _____

Account number: _____

Expiration date: _____

Signature: _____

Check enclosed

Please invoice my organization.

Please add my e-mail and additional contacts to the e-newsletter distribution list for IHIF updates.

Thank you for your commitment to IHIF's mission of creating an environment that makes Indiana a premier location for the creation and growth of health industry enterprises.

Please return this form and payment option to IHIF via fax 317.278.9971 or mail to IHIF, 351 W. 10th Street, Suite 216, Indianapolis, IN 46202.

Questions? Contact 317.278.9970