KANSAS ASSOCIATION OF HOSPITAL ATTORNEYS

APPLICATION FORM FOR 2024 MEMBERSHIP

Please complete the following.

Name: _____

Title: _____

Law Firm: _____

Address: _____

City & Zip: _____

Business Phone: _____ Fax Number: _____

Email Address: _____

Please complete one of the following statements to qualify for KAHA membership:

I am an attorney and I am employed by or represent (Hospital) _____

I am a law student at (law school):

_____

I hereby apply for membership in the Kansas Association of Hospital Attorneys and agree to pay the annual dues of $50.00.

_____ _____

Date Signature of Applicant

Please make your $50.00 check payable to the Kansas Association of Hospital Attorneys and mail it with this completed application form to:

KAHA
c/o Kansas Hospital Association
215 SE 8th Avenue
Topeka, KS 66603-3906