APPLICATION
Associate Business Member (ABM)

ORGANIZATION INFORMATION

Organization: ____________________

Mailing Address: ____________________

Web Address: ____________________

Phone: ____________________ Fax: ____________________

Product/Services (25 word description for website): ____________________

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Contact: ____________________ Title: ____________________

Phone: ____________________ E-Mail: ____________________

☐ I certify that this organization or any affiliated organization with common ownership is not eligible for regular membership as a portable diagnostic provider. *For more information on membership qualifications, visit: apdahealth.com/membership*

☐ I am affiliated with a current or past member of APDA? If so, please explain: ____________________

PAYMENT (ANNUAL DUES ARE $500)

○ Pay by Check. (*Make check payable to **APDA** and mail to: **1065 Executive Parkway Dr., STE 220, St. Louis, MO 63141-6367***)

○ Credit Card Payment: ○ Visa ○ MC ○ AMEX

Card Number: ____________________ Exp Date: ____________________

Name on Card: ____________________

Card Mailing Address: ____________________

Card Security Code: ____________________ Amount Authorized to Charge: ____________________

SIGNATURE

Signature: ____________________ Date: ____________________

FAX COMPLETED APPLICATION TO:

208-248-3794

Mailing Address:
APDA
1065 Executive Parkway Dr., STE 220
St. Louis, MO 63141-6367

Contact:
E: VendorSupport@APDAhealth.com
P: (316) 734-5888
W: APDAhealth.com