



Membership Application

Name:	
Title:	
Firm/Company:	
Street Address:	
City/State/Zip:	
E-Mail Address:	
Phone:	()
Law School Attended:	
Year Graduated:	
Currently licensed to practice law in (list state, year admitted, license number):	

What is your primary health care clientele?

<input type="checkbox"/>	Health Institutions
<input type="checkbox"/>	Health Delivery Systems
<input type="checkbox"/>	Health Professionals
<input type="checkbox"/>	Health Regulatory Agencies
<input type="checkbox"/>	Health Insurers or Payors
<input type="checkbox"/>	Health Associations
<input type="checkbox"/>	Represent, through employment or other comparable association, a legislative, executive, judicial, administrative, or other governmental branch or agency which is actively concerned with the development or application of health care law in the State of California, or in any political subdivision thereof.
<input type="checkbox"/>	Hold an academic appointment for teaching health care law.

Employment or Practice Situation:

<input type="checkbox"/>	Private Practice: Size of Firm (# attorneys):
<input type="checkbox"/>	In-House Counsel
<input type="checkbox"/>	Government
<input type="checkbox"/>	Academic

Choose up to Five (5) Practice Areas by Checking Those That Apply:

<input type="checkbox"/>	AT	Antitrust
<input type="checkbox"/>	CT	Corporate Transactions
<input type="checkbox"/>	FA	Fraud and Abuse
<input type="checkbox"/>	GEN	General Health Law
<input type="checkbox"/>	REG	Healthcare Regulations
<input type="checkbox"/>	HO	Hospitals
<input type="checkbox"/>	LE	Labor/Employment
<input type="checkbox"/>	LIT	Litigation
<input type="checkbox"/>	LTC	Long Term Care
<input type="checkbox"/>	MC	Managed Care
<input type="checkbox"/>	MH	Mental Health
<input type="checkbox"/>	MM	Medicare/Medicaid Reimbursement
<input type="checkbox"/>	MS	Medical Staff
<input type="checkbox"/>	PR	Physician Representation
<input type="checkbox"/>	PL	Professional Liability/Risk Management
<input type="checkbox"/>	TE	Tax and Tax Exemptions
<input type="checkbox"/>	UM	Utilization Management

Choose one (1) specialty area from those listed above:	
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Professional Association Board/Committee Service:

Date:	
Organization:	
Board/Committee:	
Position:	

Academic Appointments:

Date:	
Organization:	
Board/Committee:	
Position:	

Please complete the following regarding at least one California health care client (for yourself or your firm). THIS INFORMATION WILL BE HELD IN CONFIDENCE and is for internal use only to determine eligibility for personal membership:

Client/Organization:	
Address:	
City/State/Zip:	
Type of Work Performed:	
Client/Organization:	
Address:	
City/State/Zip:	
Type of Work Performed:	

Do you have any interest in service on CSHA educational faculties?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have any interest in writing articles for CSHA publications?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
In what specific areas might CSHA be of benefit or service to you?		

Please examine your application carefully. Failure to submit a completed application with your resume or curriculum vitae will result in a substantial delay in processing. Your application will be processed after receipt of dues, fees, completed application and resume or curriculum vitae.

Submit your application, fees, and curriculum vitae or resume to:

**California Society for Healthcare Attorneys
1215 K Street, Suite 800
Sacramento, CA 95814**

AMOUNT: \$255.00

(Annual dues of \$225.00 + application fee of \$30.00. Prices effective until further notice.)

We accept personal or company checks and VISA or MasterCard. To submit your application using a VISA or MasterCard, please complete the following:

Credit Card:	<input type="checkbox"/> VISA	<input type="checkbox"/> MasterCard
	Expiration Date: _____	V-Code _____ (3 digit code on signature panel of card)
Name as it appears on card:		
Billing Address:		
Card Number:		
Amount Authorized: \$ _____	Signature:	