Inspire Collaborative Health Association

Strategic Partnership Agreement

Organization Name:							
Contact Person, Title:							
Address:		City:		ST:		Zip:	
Phone:		Email:					
Website:							
List Specific Services or Goods Offered at Business:							
Business Establishment Date:		Is the business in compliance with all local, state, and federal requirements?[1]		☐ YES		☐ NO	
Would you like us to use a logo/photo from your business website for our directory?				☐ YES		☐ NO	
Would you prefer to supply us with a logo/photo for your directory image?				☐ YES		☐ NO	
There is a place for you to summarize to site visitors why you chose to join ICHA, what your company's vision or mission might be or a little bit about what services the business offers. Would you like to make a statement that we could use next to your logo photo and contact information? (500 characters or less)			☐ YES		☐ NO		

If yes, please make a statement here:

Would you like to offer fellow ICHA Members and Strategic Partners any discounts or special benefits to the services or goods offered at your business?	☐ YES	☐ NO
What discount or benefit would you like to offer?		
Would you like this discount or benefit to be offered indefinitely or on a limited basis?	☐ Indefinitely	☐ Limited
If Limited, Please specify terms of discount or benefit:		

I certify that my answers are accurate and complete to the best of my knowledge. By signing this document, I understand that I am becoming an active Strategic Partner of the Inspire Collaborative Health Association and acknowledge my information will be listed in the Strategic Partnerships directory. I understand features, benefits, co-members, and co-partners are subject to change as ICHA grows and develops.

Signature:		Date:	

[1] Specifically, licensing requirements.

Payment and Authorization

Please complete all fields. Cancellation of auto-renewal membership dues must be submitted at least one month before the annual renewal date; cancellation requests made within one month of your renewal date will be processed for the following year's membership. This authorization will remain in effect until a written cancellation is received. Annual dues and donations can not be refunded.

Reminder: Dues and donations are tax-deductible.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other
Cardholder Name (as shown on card): _____
Card Number: _____ CVV: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I,_____, authorize Inspire Collaborative Health Association to charge my credit card for Strategic Partnership dues in the amount of $1,200.00.

I understand that my payment information can be saved on file for future transactions (annual dues or authorized donations) on my account.

☐ Yes, save my card and auto-renew my dues each year. ☐ No, do not save my card for auto-renewal.

Signature:		Date:	

Would you like to make a one-time or recurring donation to help the growth, development, and mission of ICHA? This donation will help fund the recruitment of more providers, practitioners, and strategic partners, as well as the association as a whole for future banquets, seminars, and services. All donations are tax-deductible.

☐ Yes, please accept a donation of $_____.

☐ One-time donation ☐ Repeat donation ☐ Frequency: _____

☐ No, not at this time.

Signature:		Date:	

*Submission of enrollment & payment information is not a guarantee of member or partnership status. All enrollment information will be reviewed by ICHA. Payments are only processed and retained for those who meet ICHA standards. Should a business or individual submit enrollment that does not meet these standards and payment has been submitted, their payment will be returned in full.