Inspire Collaborative Health Association

Practitioner - Membership Enrollment Application

Today's Date: _____

Personal Information

Full Name: _____ DOB: _____
Last *First* *M.I.*

Home Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Personal Phone: _____ Personal Email: _____ Referred by: _____

Work Information

Place of Employment[1]:		Work Address[1]:	
Office Phone[1]:		Work Website[1]:	
Designation (MD, NP, etc.)[1]		Specialty[1]:	

Are you the owner/operator/manager of this business?	☐ Yes	☐ No

If Yes, answer the following four questions.

Business Establishment Date:			Is the business in compliance with all local, state, and federal requirements[2]?	☐ Yes	☐ No
Does the business carry a current/active form of liability insurance?	☐ Yes	☐ No	In addition to, or instead of business liability, do you carry a personal policy that covers you in your scope of practice?	☐ Yes	☐ No

[1] Will be listed in public directory
[2] Specifically, licensing requirements

Directory Preferences

Are you currently accepting new patients/clients?	☐ Yes	☐ No	☐ Waitlist	☐ By Application Only

If NO, you will still be listed in our directory, but your new patient status will be notated.

Available forms of appointments:	☐ Telehealth	☐ In Person	☐ Phone Consults

Forms of payment accepted:	☐ Insurance	☐ HSA/FSA	☐ Self Pay	☐ Payment Plans	☐ Financing Available

Can we post your picture in our directory?	☐ Yes	☐ No
Would you like us to use a headshot/photo from your current employer's website?	☐ Yes	☐ No
Would you prefer to supply a picture?	☐ Yes	☐ No
There is a place for you to summarize to site visitors why you chose to join ICHA, your personal vision or mission, or a little bit about yourself. Would you like to make a statement that we could use next to your picture and contact information? (750 characters or less)	☐ Yes	☐ No

If yes, please make a statement here: _____

_____

_____

_____

_____

_____

_____

Membership Assistance

Inspire Collaborative Health Association never wants a qualified health professional interested in our mission to miss out on the opportunity to join due to cost. Donations make it possible for us to offer assistance to professionals who qualify. Membership assistance comes in the form of a discount. Three tiers of discount are available. Tier 1 = 15% discount. Tier 2 = 25% discount. Tier 3 = 35% discount.

Are you interested in applying for membership assistance?	☐ Yes	☐ No

If yes, please fill out the included membership Assistance Application in this packet and submit it along with the rest of your enrollment paperwork. Debit or credit card information should still be included below but will not be charged until the applicant is notified of the approved discount. The discount applies to a one annual membership fee and will need to be reevaluated with an updated application one month before membership renewal.

Payment and Authorization

By providing your credit card information for the initial membership purchase, you authorize us to securely process payment. This process enables the option for automatic membership renewal using the "save credit card on file" feature. Automatic renewals will occur annually, specifically in the same month as your initial joining month. The renewal price will correspond to the pricing category the member signed onto, with any potential pricing discounts or credits applied. A single reminder will be sent prior to the renewal card processing. Please note that annual dues and donations are non-refundable and 100% tax-deductible.

Cancellation Policy: If you choose to cancel the automatic renewal, it is necessary to notify us one month prior to your renewal month or immediately at the time of the reminder. Failure to do so could result in the renewal fee being charged to your credit card.

By proceeding with the initial membership purchase, you acknowledge and agree to these terms and conditions.

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 annual membership dues in the amount of

☐ $700 – Individual ☐ $599 - Fast App Disc. ☐ Membership Assistance _____%

☐ $560 - Group 2-5 ☐ $490 - Group 6-10 ☐ $420 - Group 11-15

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 contribution towards helping our impactful galas, grants, seminars, services, and programs? All donations are 100% tax-deductible.

☐ Yes, please accept a donation of $_____. ☐ No, not at this time.

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

Signature:		Date:	

Inspire Collaborative Health Association

Practitioner - Membership Enrollment Application

To be considered for membership, proof of completion or copies of degrees, certificates, trainings, or other relevant documentation must be provided for evaluation. These documents should be submitted along with the application through our website or can all be emailed to Connect@InspireHealthAssociation.com.

Scope of Services/Modalities Rendered

List all Services/Modalities you currently engage in or intend to engage in

1.	2.		
3.	4.		
5.	6.		
7.	8.		
Do any of these Services/Modalities require credentialing under the Uniform Credentialing Act? [2]	☐ Yes	☐ No	
If YES, are you in compliance with the credentialing requirements?	☐ Yes	☐ No	☐ N/A
Do you offer any Services/Modalities that you HAVE NOT received formal training, certification, degree, or other credentialing for? (You are self-taught).	☐ Yes	☐ No	

If YES, list ALL Services/Modalities for which you have NOT received formal training, certification, degree, or other education and provide a detailed explanation regarding your qualification to offer these Services/Modalities:

1.		
2.		
3.		
Do you offer any Services/Modalities that you HAVE received formal training, certification, degree, licensing, or other credentialing?	☐ Yes	☐ No

[2] See page 8 of https://dhhs.ne.gov/licensure/Documents/UniformCredentialingAct.pdf for full listing of modalities.

Professional Credentialing—Licensure

Have you ever been or are you currently employed as a licensed professional in the State of NE?	☐ Yes	☐ No

If YES, provide the following licensing information. If NO, skip to the next section.

License #:		License Type:		Expiration:	
License #:		License Type:		Expiration:	
License #:		License Type:		Expiration:	

Have you ever been or are you currently employed as a licensed professional in any U.S. jurisdiction (state, territory, or D.C.) other than Nebraska?	☐ Yes	☐ No

If YES, list every jurisdiction in which you have been employed as a licensed professional during the past five years.

Jurisdiction:					
License #:		License Type:		Expiration:	
Jurisdiction:					
License #:		License Type:		Expiration:	

Do you hold or have you ever held a license for a business, trade, occupation, or profession, other than those previously disclosed in this application (including those not recognized or regulated in Nebraska)?	☐ Yes	☐ No

If YES, list every jurisdiction to which you have held a license and answer these questions for each license:

Jurisdiction:					
License #:		License Type:		Expiration:	
Jurisdiction:					
License #:		License Type:		Expiration:	

Have you ever applied for a license (even if the application was withdrawn or denied) in any U.S. jurisdiction that DID NOT RESULT, OR HAS NOT RESULTED, in the issuance of such license in that jurisdiction?	☐ Yes	☐ No

If YES, list every jurisdiction to which you have applied and answer these questions for each time you applied:

Jurisdiction:					
Reason for non-issuance:		License Type:		Application Date:	
Jurisdiction:					
Reason for non-issuance:		License Type:		Application Date:	

Professional Credentialing—Other than Licensure

For all non-licensed credentialing. Include completed and in-progress credentials:

Credential Type:	• Degree • Certification • Non-degree/Non-certification Trainings, Courses, Seminars • Other Credentials (explain)

College	Degree	Completion

Certification Issuer	Certification Type	Completion	Expiration

Training Issuer	Training Type	Completion	Expiration

Other/Additional	Other/Additional Type	Completion	Expiration

Are you currently active in any associations, clubs, or other memberships relating to your scope of practice?	☐ Yes	☐ No

If YES, please list:

_____

_____

Are you currently or have you ever held a leadership position for a class, course, seminar, club, or association relating to your scope of practice?	☐ Yes	☐ No

If YES, please list:

_____

_____

Since you began practicing in this field, have you practiced continuously by seeing clients regularly?	☐ Yes	☐ No

Have you ever taken longer than six months off from your scope of practice? (e.g., extended maternity leave, sick leave, other long-term breaks, unemployment, education, etc.)	☐ Yes	☐ No

If YES, please specify why you stopped practicing and for how long you didn't practice:

_____

_____

_____

_____

_____

_____

Professional Misconduct

Have you ever had a professional license be suspended, censured, placed on probation, reprimanded, disciplined, or allowed to resign or offered diversion in lieu of disciplinary action? Include matters where discipline was stayed or held in abeyance subject to diversion or other agreement and include matters deemed confidential or closed.	☐ Yes	☐ No

If YES, explain:

_____

_____

Has any professional license in any jurisdiction ever been limited, restricted, monitored, or conditioned upon compliance with any terms or conditions?	☐ Yes	☐ No

If YES, explain:

_____

_____

Disclaimer and Signature

By submitting an application to become a member of Inspire Collaborative Health Association (ICHA), the applicant acknowledges and agrees to the following terms and conditions:

1. No refunds: All fees paid to ICHA are non-refundable. Payments are only processed and retained for those who meet ICHA standards and are accepted to participate as a member.
2. Money is only returned if the application is denied, minus a $50 application & processing fee. Application to Inspire Collaborative Health Association is not a guarantee of membership. Applicants are allowed to reapply after a period of six months, provided that there have been significant changes to the information on their application.
3. Membership is not a guarantee of any increase in patient/client load. ICHA is not responsible for the growth of a clinic or practice. It is a network that offers benefits for being active in the network. Features, benefits, and co-members are subject to change as ICHA grows and develops.
4. Mission and Vision: The applicant acknowledges and agrees to the mission and vision of the association and therefore will practice within the legal limits of their skill set, scope, and/or state limits. They will not deviate, encourage, discourage, or otherwise persuade any patients/clients to alter, withdraw, or start any practice, supplement, medication, etc., that they are not legally qualified to advise on. Should a professional member practice outside their skill set, scope, and/or state limits, they are at risk of being removed from the association. All professional members (excluding Medical doctors or Providers with equivalent privileges) agree and acknowledge that they will make no claims, promises, statements, or guarantees regarding diagnosis, mitigation of disease, treatment, cures, or prevention.
5. Group Pricing: All applicants must apply within one week (7 days) of each other. Group pricing rates are contingent upon the approval of all applicants. Adding additional members at a later date is allowed but subject to paying the appropriate group price as listed in the pricing above. Should the addition of a member push the group number into the next discount bracket, the additional member will receive the price in the next bracket.
6. Removal of members: If ICHA was provided to an individual as a benefit of being employed at a company and is no longer employed, employment change must be reported in order to have the individual removed from ICHA benefits. Should the affiliated business not request the withdrawal of the member, the individual can update work information and continue to retain association benefits for the remaining time until their original contract/application expiration date. Disassociation or removal of members due to firing, resignation, or other from the affiliated group will not receive reimbursement for the difference of that lost member.
7. Individuals involved in malpractice suits or professional misconduct suits must notify the association of the occurrence and how the case is settled. Based on the resolution of the case, the individual may be subject to review by the ICHA board for a vote on their removal from the association. By omitting or failing to disclose any professional misconduct or malpractice claims, the applicant acknowledges that they may be subject to review by the ICHA board for a vote on their removal from the association.
8. Power to remove members: ICHA reserves the right to remove any member from the association for any appropriate reason.
9. Forfeiture of dues and benefits: Any professionals that voluntarily or involuntarily separate from ICHA forgo reimbursement of any annual dues or donations and lose access to benefits offered by the association.
10. Active Participation: Joining members acknowledge that to get the most benefit from the association, it is up to them to be active and take advantage of services and benefits available.

I understand that along with the application, I am required to provide supporting documentation, including degrees, certifications, or proof of classes, trainings, etc., as necessary for the evaluation process.

I certify that my answers are accurate and complete to the best of my knowledge. By signing this document, I understand that I am applying to become an active member of the Inspire Collaborative Health Association and acknowledge that my information will be listed in the member directory per my selected preferences.

By submitting an application to become a member of ICHA, the applicant acknowledges that they have read and understood the above terms and conditions, and agree to be bound by them.

Signature:		Date:	

INSPIRE™
COLLABORATIVE
HEALTH ASSOCIATION

Statements and Notices

Thank you for your interest in becoming a Member of Inspire Collaborative Health Association. We sincerely appreciate your application. Upon reviewing your submission, if your application is approved, we will promptly process your payment (unless you have already personally processed your payment through the website). You will receive a notification regarding the status of your application. Once approved, you will gain immediate access to all the valuable benefits associated with your membership. Furthermore, within four weeks of approval, you can expect to receive a comprehensive welcome packet to support you in fully embracing your membership benefits. We look forward to welcoming you as a valued member of our association.

* Submission of enrollment application and payment does not guarantee member or partnership status with ICHA (Inspire Collaborative Health Association). All enrollment information will be thoroughly reviewed by ICHA's evaluation team. Full payments will only be processed and retained for applicants who meet ICHA's standard requirements and criteria. In some cases, after careful evaluation, ICHA may determine that an applicant's experience, education, or modality does not align with our organization's vision and mission. If this occurs, any processed payment will be promptly refunded, and all payment information will be securely destroyed and disposed of in compliance with data protection regulations. The applicant will receive a formal letter of decline detailing the decision. However, applicants are welcome to reapply in the future should their experience or credentials change, providing an opportunity for reconsideration.

** Upon receipt of enrollments that include a membership Assistance Application, ICHA (Inspire Collaborative Health Association) will diligently review the provided information and make a discount determination within a period of four weeks. Subsequently, ICHA will initiate contact to notify the applicant of their annual dues amount and confirm the payment processing amount. This ensures transparency and clarity in the financial aspects of membership.