STRATEGIC PARTNERSHIP

Qualified businesses that offer health Related Services and Goods or Businesses that support the ICHA mission.

INSPIRE COLLABORATIVE HEALTH ASSOCIATION

☐ **$5,000** ☐ **$3,000** ☐ **$1,500**

WELLNESS CHAMPION

- One (Per Yr) Provider Meeting Presentation Opportunity
- ICHA Advertises Your Events On Our Social Media
- Verbal Mention at Monthly Meetings (4-6x a yr)
- Logo/Name Advertised At Monthly Provider Meetings
- Membership Certificate
- Supportive Network - Exclusive Social Gatherings
- Trusted Referral Sources
- Access Our Clinical Liaison Services For Your Customers
- Listing on Our Partnership Website Page
- One Table Of Tickets (8) to Gala ($800 value)
- Logo/Name On Gala Event Communication
- Logo/Name On Gala Sponsorship Poster At Gala
- Direct Networking Opportunities with Health Professionals
- Access Outreach Channels Reaching Thousands

HEALTH AMBASSADOR

- Verbal Mention at Monthly Meetings (4-6x a yr)
- Logo/Name Advertised At Monthly Provider Meetings
- Membership Certificate
- Supportive Network – Exclusive Social Gatherings
- Trusted Referral Sources
- Access Our Clinical Liaison Services For Your Customers
- Listing on Our Partnership Website Page
- Four (4) Tickets To The Gala ($400 value)
- Logo/Name On Gala Event Communication
- Logo/Name On Gala Sponsorship Poster At Gala
- Direct Networking Opportunities with Health Professionals
- Access Outreach Channels Reaching Thousands

VITALITY ADVOCATE

- Logo/Name Advertised At Monthly Provider Meetings
- Membership Certificate
- Supportive Network – Exclusive Social Gatherings
- Trusted Referral Sources
- Access Our Clinical Liaison Services For Your Customers
- Listing on Our Partnership Website Page
- Two (2) Tickets To The Gala ($200 value)
- Logo/Name On Gala Sponsorship Poster At Gala
- Direct Networking Opportunities with Health Professionals
- Access Outreach Channels Reaching Thousands

Individual Contact Information :

First Name : _____ **Last Name :** _____

Address : _____

Title : _____ **Phone No :** _____ **E-Mail :** _____

Business Information :

Business Organization Name : _____ **E-Mail :** _____

Full Address : _____ **City / State/Zip :** _____

Website: _____ **Phone Number :** _____

Principal First Name _____ **Principal Last Name:** _____

Date of Incorporation _____ **Legal Structure, e.g. LLC, sole proprietor, etc.** _____ **Number of Years In Business** _____

Years at Present Location _____ **Total FT/PT Staff** _____ **Number of locations** _____ **City/State of Additional Locations** _____

Provide a Short Description Of Your Company

Summarize the Nature of Your Business

STRATEGIC PARTNERSHIP

Qualified businesses that offer health Related Services and Goods or Businesses that support the ICHA mission.

As a Strategic Partner, what savings, discounts or benefit incentives would your company offer to ICHA Professional members?

As a Strategic Partner, what savings, discounts or benefit incentives would your company like to offer to the community?

STRATEGIC PARTNER DECLARATION AND AUTHORIZATION:

By submitting this application to become a strategic partner of Inspire Collaborative Health Association (ICHA), I, _____, hereby declare and authorize the following:

Accuracy of Information: I certify that all information provided in this application is true, accurate, and complete to the best of my knowledge.

Business Representation: I am duly authorized to represent the business named in this application and to enter into partnerships on its behalf.

Compliance with Standards: I understand that as a strategic partner of ICHA, our business is expected to adhere to high standards of quality, integrity, and professionalism in providing health-related services or goods.

Collaboration and Support: I agree to actively collaborate with ICHA and support its mission of bridging the gap between medical providers and alternative practitioners to promote holistic well-being in the community.

Authorization for Verification: I authorize ICHA to verify the information provided in this application and to conduct any necessary background checks or inquiries related to our business.

Agreement to Terms: I acknowledge that acceptance as a strategic partner is subject to review and approval by ICHA, and that acceptance does not imply endorsement or warranty of our products or services.

By signing below, I confirm that I have read and understood the terms outlined in this declaration and authorize ICHA to proceed with the evaluation of our application.

Signature :

Printed Name:

Title:

Date: **Business Name:**

Payment :

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other ☐ Pay By Check **Check Number:**

Cardholder Name (as shown on card):

Card Number: **CVV:**

Expiration Date (mm/yy): **Cardholder ZIP Code (from credit card billing address):**

Check Remit:
Inspire Collaborative Health Association
12020 Shamrock Plaza Ste. 200
Omaha, NE 68154

Signature Of Card Holder