International Membership Application Instructions

1. Complete each question on the application form. Please type or print clearly and make a copy for your records.
2. A one-time nonrefundable $250 USD application fee must accompany the completed forms. We accept all major credit cards or checks payable to HDA (US dollars only).
3. Make certain your application is signed by a senior company executive.
4. **You will be billed for annual membership dues once your application has been approved. Thereafter, dues are payable each year by January 31st. Annual dues for International Members are $1,100 USD per year.**
5. The completed application, with payment, should be returned to HDA at:

Email: Dues@hda.org

Fax: (202) 831-0969

Mail: HDA
Attn: Accounts Receivable
1275 Pennsylvania Avenue NW, Suite 600
Washington, DC 20004

For further information or assistance, please contact Lisa Kanfer, Vice President of Membership and Development at (202) 964-6066. Application processing may take up to 45 days.

Payments made to the Healthcare Distribution Alliance are not deductible as charitable contributions for federal income tax purposes. However, they may be deductible under other provisions of the Internal Revenue Code.

HDA is the national association representing primary healthcare distributors, the vital link between the nation's pharmaceutical manufacturers and healthcare providers. Each business day, HDA member companies ensure that over 15 million prescription medicines and healthcare products are delivered safely and efficiently to more than 200,000 pharmacies, hospitals, long-term care facilities, clinics and others nationwide. HDA and its members work daily to provide value and achieve cost savings, an estimated $42 billion each year to our nation's healthcare system.

International Membership Application

GENERAL INFORMATION:

Applicant Company: ______________________

If division or subsidiary, name of Parent Company: ______________________

Address: ______________________

City: ______________ State: ______________ Zip: ______________

Phone: ______________ Fax: ______________

Website: ______________________

Please attach a list of addresses of parent company or other divisions/subsidiaries.

Date present business was established: ______________________

Company profile* (35–200 words): ______________________

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** The company profile will be included in the membership directory and event materials. HDA reserves the right to edit as necessary.*

KEY CONTACT:

Your key contact will be the recipient of all HDA membership information, including dues invoices.

Name: ______________________

Title: ______________________

Address: ______________________

City: ______________________

State: ______________ Zip: ______________

Email: ______________________

Phone: ______________________

Fax: ______________________

Providing the e-mail addresses of additional company contacts will ensure that they are able to access the HDA website (www.hda.org) as well as receive our weekly e-newsletter.

ADDITIONAL CONTACTS:

Name: ______________________

Title: ______________________

Email: ______________________

Name: ______________________

Title: ______________________

Email: ______________________

Name: ______________________

Title: ______________________

Email: ______________________

Name: ______________________

Title: ______________________

Email: ______________________

Name: ______________________

Title: ______________________

Email: ______________________

Why do you wish to become a member of HDA? ____

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BUSINESS INFORMATION:

Please list countries in which the company is engaged in business: ____________________________

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Are there any litigation or regulatory actions pending against the applicant by federal, state or local governmental agencies or authorities? ❑ Yes ❑ No **(If yes, attach separate documentation of pending action)**

What were your total sales for your most recent fiscal year? $ ____________________ (millions)

Please indicate services provided to customers:

❑ Credit terms

❑ Full time salesman

❑ Delivery service

❑ Local inventories which consist primarily of drug and health-related items

❑ Other: ____________________

HDA'S MISSION:

Advocate for sound public policy that supports patient access to medicines and medical products through safe, efficient and effective distribution.

Lead the healthcare supply chain on policy issues, business practices and industry guidelines to inform and support member development of innovative solutions.

Convene and partner with public and private stakeholders to facilitate discussions on industry issues, provide education and support the sharing of leading practices.

❑ I have read the above mission statement of HDA and wish to promote those objectives.

Executive of Applicant Company: ____

Signature: ____

Title: ______________________________________ Date: ___________________________________

PAYMENT INFORMATION:

Total Application Fees: $250 USD

Form of Payment: ❑ ACH ❑ MasterCard ❑ Visa ❑ AmEx ❑ Check

Send ACH Payments to:
Capital One Bank Acct# 1360464586 ABA/Routing# 065000090. Remittance to: acctdept@hda.org

Company Name: ______________________________

Cardholder's Name: ______________________________

Billing Address: ______________________________

City: ____________________ State: ____________ Zip: ____________

Credit Card Number: ____________________ Exp. Date: ____________ CVV: ____________

Signature: ______________________________

Make checks payable to HDA. Your form must be accompanied by payment in order to be processed. Payments to HDA are not deductible as charitable contributions for federal income tax purposes. However, they may be deductible under other provisions of the Internal Revenue Code. Tax ID #13-1088150.

HDA INTERNAL USE:

Company Name: ______________________________

Company ID#: ______________________________

Dues Year: ______________________________