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MASSACHUSETTS HEALTHCARE FACILITY PROFESSIONALS SOCIETY, INC

2019 MEMBERSHIP APPLICATION

☐ NEW APPLICATION ☐ RENEWAL DATE: _____/_____/_____

As a member of the Massachusetts Healthcare Facility Professionals Society, you will receive a number of professional benefits:

Active Membership is available to those individuals who are directly employed in or by healthcare-related facilities (those that provide patient care), and who have responsibility in healthcare facility operations (e.g., facilities management, plant engineering, planning/design/construction, security, safety, clinical engineering, and telecommunications).
Associate Membership is available to those who through circumstance no longer meet the requirements for active membership but who wish to maintain his/her association with the Society.
Supporting Membership is available to manufacturers, vendors, contractors, distributors, service providers, architects, engineers, and others who interact with Society members as part of their businesses and professions.
Honorary Membership is available to any member with a minimum of five years active membership who has retired from active work in the healthcare engineering field. The retiring member in writing must make application to the Secretary.

Annual dues are waived for Active and Associate Member or for the calendar year. Supporting Member annual dues are **$50**, and although Supporting Members cannot vote or serve on the Board of Directors, they are eligible for all other Society benefits. Honorary members are not required to pay dues but should verify their current contact information. Please fill out the appropriate information on this application and return it with your dues payment to the address listed below, supporting members should indicate their primary service or product for inclusion in the membership list.

Join today!

Circle One Category: ACTIVE *(waived)* ASSOCIATE *(waived)* SUPPORTING *($50)* HONORARY *(free)*

PROFESSIONAL AFFILIATIONS: ASHE _____ NEHES_____ NFPA _____CHFM_____ OTHER _____

NAME: _____**TITLE:** _____

INSTITUTION/COMPANY: _____

AREA[S] of RESPONSIBILITY: _____

ADDRESS: _____**CITY:** _____**STATE:** _____ **ZIP:** _____

TELEPHONE: [ ] _____ **FAX#: [ ]** _____ **E-MAIL:** _____

HOME ADDRESS [Optional]: _____

CITY: _____**STATE:** _____ **ZIP:** _____**HOME PHONE:** _____

MAKE ALL CHECKS PAYABLE TO: MHFPS

Signature: _____

Mail check and application to:

Paul DeViller
Lahey Hospital & Medical Center
41 Mall Road, Burlington, Ma 01805

TO SEND FORM VIA E-MAIL: Type information onto the form, save the form, and e-mail it as an attachment to:
paul.d.deviller@lahey.org