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: 703-812-0539

Mail: HDA
Attn: Accounts Receivable
901 N. Glebe Road, Suite 1000
Arlington, VA 22203

For further information or assistance, please contact Lisa Kanfer, Senior Director of Membership and Development at (703) 885-0270. 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): _____

_____

_____

_____

_____

_____

** 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: _____

Name: _____

Title: _____

Email: _____

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

_____

_____

_____

BUSINESS INFORMATION:

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

_____

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

❑ Delivery service

❑ Other: _____

❑ Full time salesman

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

HDA'S MISSION:

Protect patient safety and access to medicines through the safe and efficient distribution of healthcare products and services. Create and exchange industry knowledge and best practices to enhance the value of the healthcare supply chain. Advocate for standards, public policies and business processes that produce safe, innovative and cost-effective healthcare solutions.

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

Executive of Applicant Company: _____

Signature: _____

Title: _____ Date: _____

PAYMENT INFORMATION: *A $250 USD application fee must accompany the completed application.*

Please charge my: ❑ Mastercard ❑ Visa ❑ American Express ❑ Check # _____

Company Name: _____

Cardholder's Name: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Credit Card Number: _____ Exp. Date: _____ CVV: _____

Signature: _____

Make checks payable to HDA. Payments to HDA are not tax 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.

Total to be charged: $250 USD

HDA INTERNAL USE:

Company Name: _____

Company ID#: _____

Dues Year: _____