

AHLA PRACTICE GROUP ENROLLMENT FORM

To Enroll in Practice Group(s)

An individual must be a current AHLA member to join a Practice Group. Please note that the enrollment period is matched to the individual's membership expiration, e.g., if nine months of AHLA membership remain, your Practice Group enrollment will also lapse in nine months to enable you to renew your membership and Practice Group enrollment(s) at the same time in the future.

Name _____
Member ID# _____
Firm/Organization _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____ Email _____

___ **YES, I'm a current AHLA member and I want to add these Practice Group(s) for \$50/each:**

- | | |
|---|--|
| ___ Antitrust (03) | ___ Medical Staff, Credentialing, and Peer Review (09) |
| ___ Business Law and Governance (18) | ___ Payors, Plans, and Managed Care (12) |
| ___ Fraud and Abuse (04) | ___ Physician Organizations (14) |
| ___ Health Information and Technology (05) | ___ Regulation, Accreditation, and Payment (10) |
| ___ Healthcare Liability and Litigation (06) | ___ Tax and Finance (11) |
| ___ Hospitals and Health Systems (08) | ___ Teaching Hospitals and Academic Medical Centers (02) |
| ___ In-House Counsel (01) | |
| ___ Labor and Employment (07) | |
| ___ Life Sciences (17) | |
| ___ Long Term Care, Senior Housing, In-Home Care, and Rehabilitation (13) | |

___ **I've joined at least four Practice Groups and want to add electronic access to the remaining Practice Groups for an additional \$75**

Number of PG(s): _____ (at \$50 each) = \$ _____
'PG15' Electronic Access (at \$75) = \$ _____
Total: = \$ _____

Should your total payment be miscalculated, Health Lawyers will charge you for the correct amount.

___ **Check/Money Order (U.S. Dollars, payable to American Health Lawyers Association)**

If paying by check, please [mail the form](#) and check to American Health Lawyers Association, PO Box 79340, Baltimore, MD 21279-0340.

Credit Card: VISA MasterCard American Express Diners Club Discover

If paying by credit card, you may either mail this form to the address listed above, or submit it by fax to (202) 775-2482.

Card Number: _____
Exp. Date: _____
Cardholder's Name: _____
Cardholder's Signature: _____
ZIP Code of Cardholder's Billing Address: _____