



ACLA ASSOCIATE MEMBERSHIP

Application

Company/Organization Name: _____

Individual Contact Information (please print):

Name/Title: _____

E-mail: _____

Phone: _____

Street: _____

City/State/Zip Code: _____

Annual Dues – Please check all that apply

<input type="checkbox"/> For-profit companies	<input type="checkbox"/> over \$500 million revenue	\$ 50,000
	<input type="checkbox"/> \$100 million to \$500 million	\$ 25,000
	<input type="checkbox"/> \$0 to \$100 million	\$ 5,000

☐ Professional Service Firms \$ 5,000

☐ Non-profit companies \$ 2,000

Payment Process – Checks should be made payable to The American Clinical Laboratory Association.

Please return completed application and check(s) to:

Cheryl Hawkins
American Clinical Laboratory Association
1100 New York Avenue, NW, Suite 725 West
Washington, DC 20005
chawk@acla.com
(202) 637-9466