

Member Application Form

Please note: Information submitted may require verification.

This application form is not for Medicine Professional Corporations (MPC). For MPC application, [use this form](#) instead.

Name of Organization:

Legal Name:

Corporate Mailing Address:

City:

Province:

Postal Code:

Country:

Email:

Phone Number:

Website:

Contact Information

A. Current Most Senior Executive (e.g. Executive Director, CEO, etc.)

Name:

Title:

Email:

B. Application Contact (if not Current Most Senior Executive)

Name:

Title:

Email:

C. Billing Contact

Name:

Title:

Phone Number

Email:

OHA Membership Information

1. Interest in Membership

To help us understand and respond to our membership, please indicate your reasons for becoming a member of the Ontario Hospital Association (OHA). Check all that apply below:

- ☐ Participation with the Healthcare of Ontario Pension Plan (HOOPP)
- ☐ Participation in Group Home and Auto Insurance (through The Personal Insurance Company)
- ☐ Other, please explain:

2. Effective Date

Please specify the date you would like your membership with the OHA to be effective. The date can be retro- or pro-active. If no date is specified, then membership will be effective the day the OHA Board of Directors issues the membership.

Corporate Information

The OHA uses information about your organization in our assessment of eligibility and analysis of membership class and dues. Please complete all information requested.

3. What kind of an organization are you?

Medicine Professional Corporation? Please complete [this application form](#) instead.

- ☐ Primary Care Team (e.g., Community Health Centre, Family Health Team, Indigenous health provider)
- ☐ Hospital-related organization (e.g., Foundation, Research Institute, other)
- ☐ Community health and social services provider (e.g., hospice, community mental health services)
- ☐ Association for health care professionals or organizations (e.g., professional society)
- ☐ Other:

4. Tell us about your operations including mission and work with other health care providers.

5. Explain how your operations align with the [OHA's strategic plan](#):

6. What is the principal legislation under which your organization operates?

7. Date of Incorporation:

8. How many employees do you intend to enroll in HOOPP?

9. What is the annual revenue budget for your organization?

10. What are the top sources of revenue/funding for your organization (include up to three)?

**11. Do you have a formal affiliation with any current OHA member organizations?
If yes, please describe the relationship.**

12. Please indicate other circumstances helpful in the review of your application (for example, application results from creation of new organization employing former hospital employees).

13. References

Please provide two references from executives of health system partners (e.g., hospital, long-term care facility, etc.), at least one of which must be from a current OHA member organization.

Reference 1:

Organization:

Contact Name:

Contact Phone Number:

Contact Email Address:

Reference 2:

Organization:

Contact Name:

Contact Phone Number:

Contact Email Address:

Documentation Required

This application must be accompanied by your Articles of Incorporation/Letters Patent and all amendments to them. If your organization uses a brand name that is different from the legal name, please provide supporting documentation.

Acknowledgement and Consent

I acknowledge that:

- Membership in the Ontario Hospital Association (OHA) shall not constitute an endorsement by the OHA of an organization or its products and/or services.
- Members are not permitted to use the OHA's registered marks in any branding or marketing materials or resources, without prior permission of the OHA. Use of the OHA's marks without express written consent may result in loss of membership without any refund of dues.
- The OHA may, at the sole discretion of the Board of Directors, grant or deny membership to any organization and cancel memberships.
- The OHA may request, annually or periodically, additional information about a member organization.

I consent to HOOPP providing membership information about the organization to the OHA for the purposes of verifying information relevant to the organization's OHA membership.

NOTE: Before signing this form, please confirm accuracy of content. Once the form is signed, the content cannot be changed.

Signature

Please email your completed form, along with your Articles of Incorporation to membership@oha.com.