



AmericanCollege of
HealthcareExecutives
for leaders who care®

Application for Retired Status

Apply online at my.ache.org 

Retired status is available to Members and Fellows who are retired* and are not in a compensated position. Retired status allows for continuation of all rights and privileges of ACHE membership (except serving as an elected official) at a reduced rate of \$75 annually. This fee covers the cost of mailings.

If you are a Fellow and have 25 years of total membership (allows for a combination of Member, Fellow and/or Retired statuses), consider applying for Life Status instead of Retired Status to reflect your longtime support of ACHE. Please contact ACHE at (312) 424-9400 or contact@ache.org for more information.

*If you are semi-retired, you must be working fewer than 3 days per week.

AFFILIATE ID NUMBER

Current Status: Member Fellow

FULL NAME

PHONE NUMBER

RETIREMENT DATE

MOST RECENT TITLE AND EMPLOYER

If you have not recently updated your address with ACHE, especially since your retirement, please complete this information. If you prefer, you may update your contact information in the My ACHE area of ache.org.

ADDRESS

CITY

STATE

ZIP

E-MAIL ADDRESS

You must meet the following requirements to be eligible for Retired Status:

I am currently an ACHE Member or Fellow

I am retired or semi-retired

OR I am a Member who has become disabled and am unable to work full time. (If you are a Fellow who has become disabled and unable to work, you are eligible for Life Status regardless of ACHE tenure. Consider applying for Life Status.)

I represent and warrant that the information provided on this application is accurate and complete. I agree that if I am granted this waiver, I will continue to abide by ACHE's *Bylaws, Code of Ethics* and other rules and regulations (found on ache.org).

SIGNATURE

DATE

Dues Payment Method

Check enclosed (made payable to American College of Healthcare Executives)

Credit Card (circle one)  Visa  Mastercard  American Express  Discover

Amount: \$75.00


CARD NUMBER


EXP DATE

SIGNATURE

I have already submitted payment by (circle one) Check Credit Card

Please attach documentation of receipt or cancelled check or statement, if available

Send this completed form to:  Fax: (312) 424-9405

 Mail: American College of Healthcare Executives
6876 Eagle Way
Chicago, IL 60678-3529

APRETIRE0309