HOSPITAL CENTRAL SERVICES COOPERATIVE, INC
HCSC-GROUP PURCHASING
ALTERNATE CARE MEMBERSHIP APPLICATION

Facility Name _____

Street Address _____

City _____ ***State*** _____ ***County*** _____ ***# of Beds*** _____

Phone _____ ***Fax*** _____ ***E-mail*** _____

Please provide the following information:

Administrator _____ ***E-mail*** _____

Pharmacist _____ ***E-mail*** _____

D.O.N. _____ ***E-mail*** _____

Materials Manager _____ ***E-mail*** _____

Business Office Manager _____ ***E-mail*** _____

Dietary Director _____ ***E-mail*** _____

Housekeeping _____ ***E-mail*** _____

Maintenance _____ ***E-mail*** _____

Please answer the following questions:

1. ***Is your facility affiliated with any hospital or any chain of business?*** _____
   If so, which one? _____
2. ***Do you currently belong to any other group purchasing organization? Yes*** _____ ***No*** _____
   If yes, which one? _____
3. ***Are any departments currently outsourcing services? If so, which ones? (e.g. Food Service, Laundry Service, Housekeeping Service, Pharmacy Service, P.T., O.T.)***
   _____

An annual (January 1 – December 31) membership fee of $100 must accompany this application. We hereby make application to participate in the programs offered by HCSC.

Name & Title _____
PRINT

Signature _____ ***Date*** _____