***The Hearing HealthCare Alliance of New York*, Inc.**

2025 MEMBERSHIP RENEWAL

January 1, 2025, through December 31, 2025

DISPENSING MEMBER: Full Voting Membership in the ***Hearing HealthCare Alliance of New York*, Inc.** is open to all individuals who are actively registered as a **Hearing Aid Dispenser** by New York State, **DISPENSING MEMBER EMERITUS**: individuals who have been a dispensing member of **HHCANY, INC.** for at least ten of the last fifteen years, but are no longer actively engaged in dispensing hearing aids, **ASSOCIATE MEMBER:** Non-Voting persons, organizations or businesses which do not directly engage in the dispensing of hearing aids but are involved in the hearing instrument industry or related hearing health care services or organizations and, **STUDENT MEMBER:** Persons holding a one-year **NYS Trainee Registration** or are registered in an audiology program in **NYS**.

--PLEASE COMPLETE - PAGE 1 and PAGE 2 - WITH YOUR CURRENT MEMBERSHIP INFORMATION—

NAME: _____BADGE-FIRST NAME_____

(**Active Dispensers**)****NYS Registration #140000_____** ****Expiration Date: __ __ / __ __ / __ __**

Dispensing since: _____ Member of ***HHCANY*** since: _____

****Company Name:_____** Telephone_____

Address: _____

Mailing Address (if different): _____

CELL PHONE#: _____ **FAX**: _____ ***E-MAIL:** _____ _____

Type of Membership **NYS Registration/License(s):**

DISPENSING Member: _____ **Dispenser: ___ Audiologist: ___ Other: _____**

DISPENSING MEMBER EMERITUS ____

STUDENT Member: _____ ****Supervising Dispenser: _____**

ASSOCIATE Member: _____ ****Service or Product: _____**

Other Association Memberships:

Member of: **IHS___ NYSHLA___ AAA____ ASHA____ ADA____ Other**: _____

Professional Degrees or Certifications:

I Hold: **M.S.**_____ **M.A.**_____ **Ph.D.**_____ **Au. D**____ Other: _____

BC-HIS____ (SS#__ __ __ __) ACA___CCC-A____ Other: _____

Other NYS Licenses/Registrations: _____ **Other States:** _____

Do You Need CE Credits for: **NBC-HIS/IIHIS**: ___ **ASHA**: ___ **AAA**: ___ Other: _____

***I wish my Name on my Membership Certificate to read as follows:**

(Please print and include degree and accreditation, if desired)

2025 *HHCANY* Membership Dues and Voluntary Contributions

**HHCANY* NEW MEMBERS and Renewing 2024 *HHCANY* Members

I am Enclosing Payment of :

$300.00 for my 2025 Dispensing Member *HHCANY* Dues: $_____

$50.00 for my 2025 Dispensing Emeritus *HHCANY* Dues: $_____

$150.00 for my 2025 Associate Member *HHCANY* Dues: $_____

$50.00 for my 2025 Student Member *HHCANY* Dues: $_____

I wish to make a voluntary Contribution to:

The *HHCANY* Political Action Committee (*HHCANY* PAC) of: $_____

TOTAL AMOUNT ENCLOSED: $_____

Please complete this form and return it with payment by check (payable to ***HHCANY*, Inc.)** to:

***HHCANY* 130 Washington Ave. 3rd Floor North Ste. A Albany NY 12210**

THANK YOU FOR YOUR MEMBERSHIP!