

HPH Membership Application

How to join the International HPH Network

Hospitals, health services, or organizations wishing to join the HPH Network, should first check whether a national/regional HPH network exists in their country or region. You can visit our website to see established national and regional networks: www.hphnetwork.org/members

If a national/regional HPH network exists, please forward your application to the designated national/regional HPH coordinator for approval. The national/regional HPH coordinator will then forward your application to the International Secretariat.

If there is no coordinator in your country or region, please send your application directly to the International HPH Secretariat:

International HPH Secretariat

Burchardstrasse 17
20095 Hamburg,
Germany

Phone: +49 040 22621149-0
Fax: +49 40 22621149-14
Email: info@hphnet.org

Application Form

The HPH membership application includes an HPH letter of intent, information form, and a signature page, which must be filled out to join or renew your membership.

New HPH Members

Any new organization applying for membership must fill out and submit an application form. This form affirms the intent of your hospital or health service to abide by the HPH Constitution and aim to implement health-promoting activities, strategies, and policies.

Renewing HPH Members

All HPH members must renew their membership every four years by filling out an application form. This re-affirms your commitment to the HPH network and allows the Secretariat to update changes in staff and contact details.

Annual HPH Fee per Member Hospital/Health Service *

Standard HPH Fee:	300,00 €	High-income countries
Reduced HPH Fees:	200,00 €	Middle-income countries
	150,00 €	Low-income countries

In addition, national/regional fees might apply for organizations in countries with national or regional networks. Note that in some countries these fees are collected centrally, whereas in others, fees are transferred by individual members. For further information, please consult your national/regional network coordinator.

* Country income levels are based on the World Bank Group's country income classifications for 2019-2020



HPH Letter of Intent

This letter of intent, signed by management, declares that the member hospital, health service, or organization will abide by the constitution of the International Network of Health Promoting Hospitals and Health Services (HPH) and implement health-promoting activities according to the HPH Constitution, HPH strategies, and HPH policies.

Please indicate your reasons and expectations for joining by answering the following questions¹:

Please select your membership level:

- ☐ Join as a hospital ☐ Join as a health service ☐ Join as an affiliated member

1. What does your organization aspire to gain by being a member of the International HPH Network?

2. List your experience with health promotion activities/projects, strategies, or policies, that you want to share with the HPH network. What is the focus of these initiatives?

¹ This letter of intent does not constitute a binding declaration or legal force. The statements will be treated confidentially and accessed by the International HPH Secretariat and Governance Board only.



3. What actions do you plan to initiate in your first year of membership?

4. What do you expect to achieve during the four-year membership period?

5. How did you find out about HPH?

☐ *Colleague*

☐ *Conference*

☐ *Internet search*

☐ *N/R network*

☐ *Scientific article*

☐ *WHO*

☐ *Other. Please specify:*

Further comments:

This Letter of Intent shall come into force on the date of signature and will run for a period of four (4) years from that date.



Hospital/Health Service Information

☐ New member ☐ Renew for member number: _____

Name of hospital/health service/association in English

Name of hospital/health services/association in local language

Address

Street: _____

Zip Code: _____ City: _____

State: _____ Country: _____

Phone: _____ Fax: _____

Website: _____

Chief Executive Officer of hospital/health service/association

Name and title: _____

Phone: _____ Fax: _____ E-mail: _____

HPH Coordinator of hospital/health service/association

Name and title: _____

Phone: _____ Fax: _____ E-mail: _____

Name of national/regional HPH Network Coordinator (where applicable)

Name of network: _____

Name and title: _____

Phone: _____ Fax: _____ E-mail: _____



Signatures

This Letter of Intent shall be signed by the hospital/health service management and the national/regional HPH Network Coordinator (if applicable), who will send it to the International HPH Secretariat:

Hospital/health service/association management

Name and title: _____

Date and signature: _____

Name of national/regional HPH Network Coordinator

Name and title: _____

Date and signature _____

NOTE: If no national/regional HPH network exists in your area, please send this letter directly to the International HPH Secretariat for signature:

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