



MEMBERSHIP APPLICATION

Ohio Hospital Telecommunications Association Inc.

P.O. Box 5390
Cleveland, Ohio 44101

NAME: _____

ORGANIZATION: _____

TITLE: _____

STREET: _____

CITY: _____ ST: _____ ZIP: _____

PHONE: () _____ FAX: () _____

SYSTEM MANUFACTURE: _____ Model: _____

E-MAIL: _____

Membership Dues - January 1, 20____ through December 31, 20____

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TYPES OF MEMBERSHIPS:

- FULL -** Employed by a health care facility. One (1) full membership per location.
- PROFESSIONAL -** Non-member individual working in a health care facility in the State of Ohio.
- ALUMNI -** Former full members who no longer meet the "Full" Membership requirement due to retirement or unemployment.
- ASSOCIATE -** Out-of-State individuals who work in a health care facility.

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Please indicate appropriate membership that you are applying for:

FULL \$40.00 PROFESSIONAL \$40.00
 ALUMNI \$20.00 ASSOCIATE \$40.00

Please complete this form and send with a check to:

OHIO HOSPITAL TELECOMMUNICATIONS ASSOCIATION, INC.
 P.O. Box 5390
 Cleveland, OH 44101

White Copy - Treasurer

Yellow Copy - Membership Chairperson

Pink Copy - Applicant