



VENDOR MEMBERSHIP APPLICATION

Ohio Hospital Telecommunications Association Inc.

P.O. Box 5390
Cleveland, Ohio 44101

ORGANIZATION NAME:

REPRESENTATIVE NAME:

IMMEDIATE SUPERVISOR:

STREET:

CITY: ST: ZIP:

PHONE: () FAX: ()

OHTA MEMBER SPONSOR'S NAME:

E-MAIL:

Membership Dues - January 1, 20 through December 31, 20 = \$150.00

YOUR COMPANY'S MAJOR
PRODUCT LINE(S)

AGE PF
PRODUCT LINE(S)

DISCOUNTS OFFERED TO OHTA MEMBERS:

WHAT DO YOU EXPECT FROM OHTA MEMBERSHIP:

HOW CAN OHTA BENEFIT FROM YOU:

WOULD YOUR FIRM BE WILLING TO SPONSOR:

Lunch Cocktails Door Prize Other

(If other, please explain)

Name

Health Care References
Organization

Phone Number

Please complete this form and send with a check and vendor membership agreement to:

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

White Copy - Treasurer

Yellow Copy - Membership Chairperson

Pink Copy - Applicant