



PROFESSIONAL ASSOCIATION OF HEALTH CARE OFFICE MANAGEMENT

MEMBERSHIP APPLICATION

Name _____ Job Title _____

Practice Name _____

Practice Address _____ Suite _____

Practice City _____ State _____ Zip _____

Practice Phone () _____ Fax () _____

E-mail _____

Home Address _____

Home City _____ State _____ Zip _____

Home Phone () _____ Fax () _____

I wish to receive PAHCOM materials mailed to: Practice Home

Local PAHCOM Chapter affiliation: _____

Formal Education Completed:

- _____ High School
- _____ Associates Degree
- _____ Bachelors Degree
- _____ Masters Degree
- _____ Doctorate
- _____ Other _____

- Years in Health Care _____
- Specialty of Practice _____
- Number of Doctors _____
- How were you referred to PAHCOM? _____

PAHCOM MEMBERSHIP PLEDGE

I agree to promote the professionalism of PAHCOM through the pursuit of excellence in health care office management and to further support the Association by responding to PAHCOM surveys to the best of my ability. Enclosed is my payment for \$165.00 made payable to PAHCOM for my annual membership dues. I understand my membership is non-transferable and is valid for 12 months from the date of issue.

Signature: _____

Date: _____

METHOD OF PAYMENT Check (Please make payable to PAHCOM)
 Credit Card (Personal or Corporate)

Credit Card # _____ / _____ / _____ / _____

Exp Date: ____ / ____ Card Code: _____

Cardholder's Name: _____

Billing Address for Card: _____

