DAYTON CHAPTER OF PAHCOM
2017 MEMBER APPLICATION

New Applicant _____ **Renewal Application _____**

Name: _____

(Print name as you wish it to be listed in the directory, along with credentials.)

PAHCOM National Member Number: _____ **Date of National Renewal**: _____

**Chapter By-Laws require active National Membership. If you are not a National member at the time of this application, you will have 60 days from the date of membership with the Dayton Chapter to provide your National Member Number to the Membership Director. If proof of National Membership is not received within these 60 days, dues paid to the Dayton Chapter will be forfeited and local membership will be cancelled.*

Employer Name: _____ Job Title: _____

Office Address: _____ Home Address: _____

City/State Zip: _____ Home City/State Zip: _____

Office Phone#: _____ Home/Cell#: _____

***Home/Cell info will not be distributed. Only for Executive Board use in case of emergency.*

Preferred email: _____

How many of the following do you manage: practices _____ doctors _____ mid-levels _____

Private practice(s)/Network practice(s): _____

If you do not directly manage staff, please explain: _____

_____

Do you currently do business with any PAHCOM members/vendors? If so, please list: _____

_____

Please list other professional organizations to which you belong: _____

_____

Annual Membership Dues: $50.00
Please make check payable to: *Dayton Area Chapter of PAHCOM*
Dues paid for membership will follow the payer.

Signature: _____ Date: _____

Please complete and return with membership payment to:

Dayton Area Chapter of PAHCOM
Attn: Membership Director
P.O. Box 293037
Kettering, OH 45429

WE APPRECIATE YOUR MEMBERSHIP AND SUPPORT. THANK YOU!

OFFICE USE ONLY: Check Date and Number _____ Business _____ Personal _____ Initials _____