MEMBERSHIP APPLICATION – FY 10

September 1, 2009–August 31, 2010

NCTTRAC North Central Texas Trauma Regional Advisory Council

Please return completed Membership Application by mail, fax or scanned email attachment to the attention of Vicki Thedford at: NCTTRAC - 600 Six Flags Drive, Suite 160 - Arlington, TX, 76011
Phone: 817.608.0390 - Fax: 817.608.0399 - Email: NCTTRAC_Admin@ncttrac.org

____
(Organization/Individual Name)

____
(Street) (City) (County) (Zip)

____
(Primary Designated Representative's Name – One per Organization)

____
(Phone Number) (Fax Number) (Email Address)

MEMBER CLASSIFICATION & FEES

Per the by-laws of NCTTRAC, annual dues (September – August) are assessed based on your classification with the Texas Department of State Health Services. Please check one of the following, filling in your calculated fees based on your associated bed/ambulance/asset information as applicable:

		Calculated Fee
Voting Membership:		
____Hospitals/Medical Facilities	($125 plus ______ # licensed beds X $1.25)	= ___________
____EMS/Ambulance	($ 25 plus ______ # licensed ambulances X $15)	= ___________
____Air Ambulance	($125 plus ______ # helicopter/fixed wing assets X $15)	= ___________
____Schools and Colleges	($ 75)	= ___________
____Physicians Groups	($ 75)	= ___________
____Professional Associations/Organizations	($ 75)	= ___________
____First Responders/Volunteers	($ 15)	= ___________
Associate (Non-Voting) Members:		
____Individuals	($ 30)	= ___________
____Organizations (non-health related)	($ 75)	= ___________
Initial/Renewal Membership:		
If you are a new member, a fee of $125 is required in addition to the dues listed above.		
____ New Member	($125, excluding Individuals, First Responders/Vols)	= ___________
____ Renewal (sustained/continuous membership)	($ 0)	= ___________
	Total Estimated Fee(s)	= ___________

I/my organization acknowledge(s) responsibilities as a member and essential component of the emergency healthcare system established by the State of Texas for the nineteen counties comprising Trauma Service Area – E. I affirm its/my willingness to comply, as appropriate, with state and/or regional guidelines, obligations and by-laws as presented by the North Central Texas Trauma Regional Advisory Council (NCTTRAC) and its Board, generally found on www.NCTTRAC.org.

Authorized Signature (V.P. equivalent or above)	Printed Name	Date of signature
Title	Texas Hospital/Provider License #	Expiration Date

** Payment of fees to NCTTRAC will be requested by mailed invoice after final review / approval of the member application.

******* BELOW THIS LINE FOR NCTTRAC USE ONLY***

APPROVAL / DISAPPROVAL

NCTTRAC Staff Recommendation	Comments (if any)	Initials	Date

APPROVED / DISAPPROVED

NCTTRAC Board Review/Decision	Comments (if any)	Date