



Ohio Ambulance & Medical Transportation Association

MEMBERSHIP APPLICATION

PLEASE TYPE OR PRINT

Company Name _____

Mailing Address _____

City _____ State _____ Zip _____

Telephone _____ FAX _____ E-Mail _____ Web-site _____

Have Been Operating Since (Month and Year) _____ Medicare Provider Yes No Medicaid Provider Yes No

Referring Company or Individual (optional) _____

Medical Transportation Services Offered (check all that apply)

- MoICU
- Basic Life Support
- Advanced Life Support
- Air Ambulance
- NonEmergency Transportation
- Wheelchair

Please check appropriate membership category.

ACTIVE MEMBER (Voting) - Any entity or authority engaged in the business of providing medical transportation licensed by the Ohio Ambulance Licensing Board and agreeing to abide by the bylaws of the Ohio Ambulance and Medical Transportation Association.

Annual membership dues: \$300, plus per vehicle rate, based on number of ambulance, MoICU and wheelchair vehicles. (check all that apply)

	# of vehicles			
Licensed ambulance vehicles	_____	x \$40 per	Total for ambulance	\$ _____
Wheelchair/ambulette vehicles	_____	x \$20 per	Total for ambulette	\$ _____
MoICU's	_____	x \$60 per	Total for MoICU	\$ _____
Base Membership Dues				\$ 300
*Additional mailings @ \$35 ea.				\$ _____
Total Payment - Active			=	\$ _____

ASSOCIATE MEMBER - (Non-voting) All other entities in the business of providing medical transportation and agreeing to abide by the bylaws of the Ohio Ambulance and Medical Transportation Association

Annual membership dues: \$425.

Amount enclosed - Membership	\$ _____
*Additional mailings @ \$35 ea.	\$ _____
Total Payment - Associate = \$ _____	

*On the reverse side, please list names of individuals to receive separate mailings/communications within your organization.

I understand that this application is subject to the approval of the Ohio Ambulance and Medical Transportation Association and that until it has been reviewed and acted upon, I understand that I shall be designated a Member-Applicant. Further, I understand that the first year's membership dues shall be payable at the time of this application, and that if for any reason this application is refused, the dues will be refunded in full. If elected to the membership, I pledge to conform to the articles, bylaws, code of ethics, professional standards and other official acts of the Ohio Ambulance and Medical Transportation Association.

OAMTA PO Box 3188 Dublin OH 43016
(614) 659-0198 FAX (614) 336-8596

Submitted by (Contact person) _____ Title _____

OAA
T.I.N. 34-6619511

Signature _____ Date _____



Credit Card Payment Form

Member /Company _____

Contact Person _____

Telephone _____

Total amount to be charged _____

Please indicate if payment is to be made by:

Cash

Check (Payable to "OAMTA", PO Box 3188; Dublin OH 43016)

or:

Credit Card, charge to:

Visa

MasterCard

Am. Express

Acct: No. Exp. Date _____

Cardholder's Name _____

Zip Code of Billing Address _____

Signature _____