Company Name: _______________________________________________________________

Primary Contact Person: _______________________________________________________

Street Address: ___________________________________________________________________

City: ___________________________ State: ___________ Zip: ______________________

Phone: __________________ Fax: ___________ Email: ______________________

Website: ______________________________________________________________________

Operating Since (Mo/Year): ______________ Medicare Provider (Y/N): __________ Medicaid Provider (Y/N): __________

Medical Transportation Services Offered (check all that apply):

☑ MoICU ☑ Air Ambulance ☑ Basic Life Support
☑ Nonemergency Transport ☑ Advanced Life Support ☑ Wheelchair

Please check the appropriate membership category:

☐ Active Member (voting):
Any entity or authority engaged in the business of providing medical transportation licensed by the Ohio Medical Transportation Board and agreeing to abide by the bylaws of the Ohio Ambulance and Medical Transportation Association. Annual membership dues: $315, plus per vehicle rate, based on number of ambulance, MoICU and wheelchair vehicles. Total amount of dues not to exceed $4,000 for a single company.

# of Licensed Ambulance Vehicles __________ x $50 per total for ambulance ________
# of Licensed Wheelchair/Ambulette Vehicles __________ x $25 per total for ambulette ________
# of Licensed MoICUs __________ x $80 per total for MoICU ________
# of Licensed Air Medical Units __________ x $110 per total for air medical ________
Base Membership Dues $315

Total Payment $___________

☐ 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 $435.

Flat Fee Membership Dues $435

Please list any additional individuals you would like to receive Association communications on behalf of your organization.

Name ___________________________ Title ___________________________ Email __________

1. ______________________________________________________________________
2. ______________________________________________________________________
3. ______________________________________________________________________

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.

_____________________________________________________
Submitted by (authorizing agent) Title ___________________________

_____________________________________________________
Signature Date
Payment

Please select your preferred method of payment:

☐ Check
Make checks payable to
“Ohio Ambulance and Medical Transportation Association”
155 East Broad Street, Suite 2020 Columbus, Ohio 43215

☐ Visa  ☐ MC

Credit Card Number: _________________________________
Cardholder Name: _______________________________________
Amount to be Charged: __________________ Billing Zip: __________
Cardholder Signature: _______________________________________

OAMTA T.I.N. 34-6619511
Tax deductibility of membership dues: As a non-profit 501-C-6 tax-exempt trade association, dues to OAMTA may be deductible for federal income tax purposes as ordinary and necessary business expenses except for an amount that such dues are spent on lobbying activity.