

PROFESSIONAL ASSOCIATION OF HEALTH

CARE OFFICE MANAGEMENT

VENTURA COUNTY CHAPTER

MEMBERSHIP APPLICATION

Name _____ Job Title _____

Practice / Employment Name: _____

Practice / Employment Address _____ Suite _____

Practice / Employment City _____ State _____ Zip _____

Practice / Employment Phone _____ Fax _____

E-mail _____ @ _____

Home Address _____

Home City _____ State _____ Zip _____

Home Phone _____ Fax _____

I wish to receive PAHCOM materials at my: Practice Home

Local PAHCOM Chapter:

VENTURA COUNTY CHAPTER

Years as a medical office manager / practice administrator / supervisor: _____

Practice Specialty _____ Number of Physicians _____

Formal education completed:

High School Associates Degree Bachelors Degree Masters Degree Doctorate Other _____

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's 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 valid for 12 months.

Signature: _____ Date: _____

METHOD OF PAYMENT

Checks Only Check# _____

MAIL TO: PAHCOM

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La Mesa, CA 91941

Phone: 800-451-9311

Fax: 407-386-7006

WEB SITE: www.pahcom.com

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