

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,
NANCY KENNEDY, AREA REPRESENTATIVE**

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 \$125 made payable to PAHCOM for my annual membership dues. I understand my membership is valid for 12 months. If your doctor is a VCMA member, you will receive a \$25.00 discount.

Signature: _____

Date: _____

METHOD OF PAYMENT

Checks Only Check# _____

MAIL TO: PAHCOM, 4700 W. Lake Ave., Glenview IL 60025

TEL: 800-451-9311 **FAX:** 847-375-6495 **WEB SITE:** www.pahcom.com

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