

PROFESSIONAL ASSOCIATION OF HEALTH CARE OFFICE MANAGEMENT
METROLINA CHAPTER MEMBERSHIP APPLICATION



Name _____ Credentials _____

Practice Name _____

Address _____

City, State, ZIP _____

Office Phone _____ Cell Phone _____

E-mail _____ Fax _____

PAHCOM National Membership Number _____

Membership Type Professional (\$155) Student (\$60) Includes monthly lunches

Membership Pledge

I agree to promote the professionalism of PAHCOM through the pursuit of excellence in healthcare office management and to further support the goals of the association to the best of my ability. I understand that my membership is valid for one calendar year, and is nontransferable and nonrefundable.

New Member Signature _____ Date _____

Membership Officer Signature _____ Date _____

Please bring the completed application to the next Local Chapter meeting, with your check made payable to MCPAHCOM, or mail them to:

Richard van der Kraan, CMM
c/o Lakeside Family Physicians - Denver
7482 Waterside Crossing Blvd ste 202
Denver, NC 28037

Membership in the Metrolina Chapter of PAHCOM requires active membership in
the National Association of PAHCOM