



MEMBERSHIP APPLICATION/RENEWAL – FY 18

September 1, 2017 – August 31, 2018

Please return completed Membership Application by mail, fax, or scanned email attachment to NCTTRAC Membership at:
 NCTTRAC - 600 Six Flags Drive, Suite 160 - Arlington, TX, 76011
 Phone: 817.608.0390 ▪ Fax: 817.608.0399 ▪ Email: Admin@ncttrac.org

_____ New Member* (\$125 Fee)

(Organization Name)

_____ (Street) _____ (City) _____ (County) _____ (Zip)

_____ (Primary Voting Representative's Name – One per Organization) _____ (Title / Position)

_____ (Phone Number) _____ (Fax Number) _____ (Email Address)

MEMBER CLASSIFICATION & DUES

(Please remit no later than October 30, 2017. Payments received after October 30th will assess \$125 new member fee)
 According to NCTTRAC Bylaws, annual dues (September – August) are assessed based on your classification with the Texas Department of State Health Services as of the invoice date. **The attached invoice is based on the information below. Please verify this information for accuracy and report any changes to NCTTRAC at 817.608.0390 or Finance@ncttrac.org.**

Voting Membership:	Calculated Fee
_____ Hospitals/Medical Facilities (\$2,000 plus _____ # licensed beds X \$15.00)	= _____
_____ Free Standing Emergency Department (\$2,000 plus _____ # treatment stations X \$15.00)	= _____
_____ EMS/Ambulance (_____ # licensed ambulances X \$100)	= _____
_____ Air Ambulance (_____ # helicopter/fixed wing assets X \$100)	= _____
_____ Schools and Colleges (\$ 100)	= _____
_____ Physicians Groups (\$ 100)	= _____
_____ Professional Associations/Organizations (\$ 100)	= _____
_____ First Responders/Volunteers (\$ 100)	= _____
New Member Fee \$125, excluding First Responders/Volunteers (If Applicable)	= _____
Total Dues/Fee(s)	= _____

***New Member:** 'New Member' is classified as an organization who has not been a member of NCTTRAC as of the last Membership Year and/or have not renewed current membership as of October 30, 2017. If you are a New Member, a fee of \$125 is required in addition to the dues listed above.

My organization wants to be a voting or active participating NCTTRAC member.
 My organization acknowledge(s) responsibilities as a member and essential component of the emergency healthcare system established by the State of Texas for the nineteen counties comprising Trauma Service Area – E. I affirm its willingness to comply, as appropriate, with state and/or regional guidelines, obligations, and by-laws as presented by the North Central Texas Trauma Regional Advisory Council (NCTTRAC) and its Board, generally found on www.NCTTRAC.org.

_____	_____	_____
Authorized Signature **	Printed Name	Date of signature
_____	_____	_____
Title	Texas Hospital/Provider License #	Expiration Date
_____	_____	_____
E-mail Address	Telephone	
_____	_____	

Authorized Signature must be a Vice President (or above) / Assistant Chief (or above) **who is authorized to appoint representation

-----**BELOW THIS LINE FOR NCTTRAC USE ONLY**-----

RECOMMEND / NOT RECOMMEND NCTTRAC Staff Recommendation	_____	_____
	Comments (if any)	Initials
_____	_____	_____
APPROVED / DISAPPROVED NCTTRAC Board Review Discussion	_____	_____
	Comments (if any)	Initials
_____	_____	_____

