



# MEMBERSHIP APPLICATION/RENEWAL – FY 19

## September 1, 2018 – August 31, 2019

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, 2018**)

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.**

<u>Voting Membership:</u>			<u>Calculated Fee</u>
_____ 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) = _____			

**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](http://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

Current / In Active Pursuit Trauma Designation level \_\_\_\_\_ Current Stroke Designation Level \_\_\_\_\_ Current Neonatal Designation Level \_\_\_\_\_

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

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