

Organization Name Returning Member New Member

Address City Zip Code

DSHS License Number (If Applicable) Expiration Date

MEMBER ORGANIZATION REPRESENTATION

Please provide the name of the organization’s Authorized Signatory and Primary Voting Representative. Authorized Signatory must be a Vice President (or above) / Assistant Chief (or above) **who is authorized** to appoint representation.

By applying, my organization commits to active participation and NCTTRAC Member in-good-standing status.
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 rules and/or North Central Texas Trauma Regional Advisory Council (NCTTRAC) Board and/or Membership-approved regional guidelines and obligations as found on www.NCTTRAC.org.

Authorized Signatory’s Name Title / Position

Phone Number Fax Number Email Address

Authorized Signatory’s Signature Date of Signature

By checking this box, I, as Primary Voting Representative, commit to delegated representative updates.
I acknowledge my responsibilities to review my organization’s contacts and delegates in the NCTTRAC Contact Management Program (powered by GrowthZone) once my organization’s membership is approved by the NCTTRAC Board of Directors.

Primary Voting Representative’s Name Title / Position

Phone Number Fax Number Email Address

Primary Voting Representative’s Signature Date of Signature

