

APPLICATION FOR MEMBERSHIP

Name \_\_\_\_\_

Practice Name \_\_\_\_\_

Phone Number \_\_\_\_\_ \*National PAHCOM Number \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email address \_\_\_\_\_

Dues 30.00

**\* MUST BE NATIONAL PAHCOM MEMBER WITH ACTIVE STATUS TO JOIN**

Dues are payable each year by March 31. New members prorated after June 30.

Amount Enclosed \_\_\_\_\_ Check made payable to CPCP

Credit Card: Visa Mastercard (Circle One)

Name on Card: \_\_\_\_\_ Exp \_\_\_\_\_

Zip Code for authorization \_\_\_\_\_

Signature \_\_\_\_\_ Amount: \_\_\_\_\_

Mail/Email to:

Gerri Botos, CMM, Treasurer  
Orthopaedic Assoc of NE Ohio  
21000 Miles Pkwy  
Cleveland, OH 44128-5512

Phone: 216-332-7864  
Fax: 216-475-6788  
Email: gerri@oano.cc