

The benefits of a
TORCH Hospital Membership

Get Connected

About TORCH

Texas Organization of Rural & Community Hospitals (TORCH) is the voice and principal advocate for rural and community hospitals in Texas. We provide leadership in addressing the special needs and issues of these hospitals. For more information, call (512) 873-0045 or visit the website at torchnet.org.

At TORCH we strive to demonstrate our value and commitment to our members through valuable programs, services, education, advocacy, publications, professional development and representation.



TORCH
 P.O. Box 203878
 Austin, TX 78720-3878
 (512) 873-0045
 www.torchnet.org

Be and Get Involved

As a TORCH Hospital Member,

You will have exclusive access to an array of rural health care resources, services, programs, tools and opportunities to assist you in your current position and future health care career endeavors, including:

- Advocacy and representation,
- Useful and timely information,
- Resource documents and publications,
- Opportunity to use the TORCH logo in marketing materials,
- Potential for marketing opportunities at other conferences or meetings,
- Educational programs designed specifically for rural and community hospitals,
- And more!

Gain Experience

Ownership/Type Categories: *(check applicable category below)*

- Governmental/Public
 - District: Supported by a local hospital district
 - Authority: Supported by a local hospital authority
 - City: Supported by the city
 - County: Supported by the county
- Not-for-Profit
 - Church-related
 - Other, including NFP Corp
- For-Profit
 - Investor-owned
 - Corporation
 - Partnership

Number of Licensed Beds _____

Number of Staffed Beds _____

DSHS Region/Zone _____

Management Type: *(check applicable category below)*

- Independent Administration
- Corporate: part of a larger system
- Managed: operated by an outside company
- Leased: Under an ownership agreement

By: _____

| | | |
|------------------|---------------------------------|--------------------------------|
| JCAHO Certified? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
|------------------|---------------------------------|--------------------------------|

| | | |
|----------------------|--------------------------|--------------------------|
| Does hospital have: | | |
| Rural Health Clinic? | <input type="checkbox"/> | <input type="checkbox"/> |
| Home Health Care? | <input type="checkbox"/> | <input type="checkbox"/> |

| | | |
|---------------------|--------------------------|--------------------------|
| Designation: | | |
| Sole Community? | <input type="checkbox"/> | <input type="checkbox"/> |
| Medicare Dependent? | <input type="checkbox"/> | <input type="checkbox"/> |
| Critical Access? | <input type="checkbox"/> | <input type="checkbox"/> |

*We hope you consider the benefits that a TORCH Hospital Membership offers and join our effort to support Texas rural and community hospitals.
 To sign-up, see the application on back!*

TORCH Hospital Membership & Payment Form

New Member: Renewal:

Hospital Name: _____

Administrator Name: _____

Email: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____ Fax Number: _____

Hospital (in state) General acute care hospital, less than 150 beds in size

A. Annual Gross Revenue
Less than \$10 million: \$1,750

B. Annual Gross Revenue
\$10 to \$50 million: \$2,850

C. Annual Gross Revenue
More than \$50 million: \$3,550

Hospital (out of state) General acute care hospital, less than 150 beds in size

A. Annual Gross Revenue
Less than \$10 million: \$1,750

B. Annual Gross Revenue
\$10 to \$50 million: \$2,850

C. Annual Gross Revenue
More than \$50 million: \$3,550

Membership Fee Enclosed: _____

DUES YEAR: JANUARY 1 – DECEMBER 31

Make check payable to: TORCH. Mail to P. O. Box 203878, Austin, Texas 78720-3878.

—OR— Use the credit card form below

Today's Date: _____ Amount Enclosed: _____ Check Enclosed:

VISA: MC: AMEX: DISCOVER: Exp Date: _____ Security Code: _____

Credit Card Number: _____

Company Name: _____

Person Authorized to Charge: _____

Signature Authorizing Charge: _____

Billing Address: _____

City: _____ State: _____ ZIP: _____

Email Address: _____

Phone: _____