Texas Association of Rural Health Clinics

P.O. Box 203878, Austin, TX 78720 (512) 873-0045/FAX (512) 873-0046/PHONE

MEMBERSHIP APPLICATION

(for corporate members, see next page)

Date _____

CLINIC MEMBERSHIP

Rural Health Clinic _____ County _____

Type of Clinic ❑ Hospital-based ❑ Independent ❑ Certified: ❑ Yes ❑ No Date Certified _____

Address/City/ZIP _____

Designated Representative _____ Title _____

Phone _____ Fax _____ Email _____

If Hospital-based, name of hospital _____

If Independent, indicate clinic ownership _____

_____

BENEFIT FOR NEW OR CURRENT CLINIC MEMBERS: with completion of this application, you receive joint membership in both Texas Association of Rural Health Clinics and National Association of Rural Health Clinics at a savings of $225! **Payment can be made by check or credit card.**

TYPES OF CLINIC MEMBERSHIP: *(check one)*

REGULAR MEMBERSHIP
Single, independent or hospital-based certified rural health clinic

❑ $375 – TARHC MEMBER ❑ $200 – ADDITIONAL CLINIC MEMBER

TARHC/NARHC JOINT MEMBERSHIP

❑ $600 – JOINT ❑ $230 – ADDITIONAL JOINT

Thank you for your membership!

PAYMENT INFORMATION

Mail check to:
P.O. Box 203878, Austin, TX 78720
or fill out credit card information on the back side.

PAYMENT INFORMATION IS ON THE BACK, PLEASE FILL OUT AND COMPLETE TO BE PROCESSED

CORPORATE MEMBERSHIP

❑ $400 – CORPORATE (Companies doing business with RHCs)

Individual/Organization name _____

Designated Representative _____

Address _____ City _____ ZIP _____

Phone _____ Fax _____ Email _____

Company description (25 words or less) _____

_____

_____

TARHC CREDIT CARD PAYMENT INFORMATION

Total amount paid $ _____ Date _____

Name as it appears on card _____

PERSON AUTHORIZED TO CHARGE

Name _____

Card Type ❑ VISA ❑ MasterCard ❑ American Express ❑ Discover

Card number _____ Expiration date _____

Card security code _____ (3-digit number on back of card, 4-digit on front for AMEX)

Signature authorizing charge _____

BILLING ADDRESS ***(please enter the following information exactly as it appears on your credit card statement)***

Address _____

City _____ State _____ ZIP _____

Email address _____

Phone number _____

Payment cannot be processed unless all information is provided.