



## Professional Association of Health Care Office Management Student Membership Application

Name \_\_\_\_\_

Name of School \_\_\_\_\_

School Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZipCode+4 \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZipCode+4 \_\_\_\_\_

E-mail Address \_\_\_\_\_ Cell phone No. \_\_\_\_\_

Work Telephone \_\_\_\_\_ Work Fax \_\_\_\_\_

Home Telephone \_\_\_\_\_ Home Fax \_\_\_\_\_

Mail material to my:  Home  School

Student anticipated studies completion date: \_\_\_\_\_

Years in healthcare \_\_\_\_\_ Professional Designations you hold: \_\_\_\_\_

Education Completed: High School  Associate  Bachelor  Master  Doctorate

Other \_\_\_\_\_

How were you referred to PAHCOM? \_\_\_\_\_

Send information on the certification examinations.

### PAHCOM Membership Pledge:

I agree to promote the professionalism of PAHCOM through the pursuit of knowledge in healthcare management, and to further support the Association by responding to PAHCOMS' survey questionnaires to the best of my ability. Enclosed is my payment \$125 for my annual membership (valid for 12 months from date of issue).

Signature \_\_\_\_\_

Date \_\_\_\_\_

I agree to the terms and conditions above

Annual Student Membership \$125

### Method of Payment

Check

AMEX

MASTERCARD

VISA

DISCOVER Card

Card # \_\_\_\_\_ Exp. Date \_\_\_\_\_ Four Digit Card Code \_\_\_\_\_

Fax to: 407-386-7006

Mail to: PAHCOM Membership, 1576 Bella Cruz Drive, Suite 360, Lady Lake, FL 32159