PO Box 11330 * El Dorado, AR * 71730 Ph. 870-875-2273 Fax 870-881-8989

APPLICATION FOR MEMBERSHIP

ORGANIZATION DATA

Organization Name _____

Type of Organization: [ ] Volunteer [ ] Hospital [ ] Government [ ] Private

[ ] Public Utility Model [ ] Vendor / Associate

Service License Level: [ ] SP [ ] I-B [ ] I-A [ ] Int. [ ] P [ ] Air

License Number: _____ Service Area / County: _____

CONTACT INFORMATION

Contact Person_____ Title_____

Mailing Address_____

City_____ State_____ Zip Code _____

Daytime Phone No. _____ Fax No. _____

Contact E-mail(s):

Name	E-mail Address	Position/Title

MEMBERSHIP DUES:

Affiliate Membership ……	$100 per year	Volunteer (non-billing) Providers ……	$25 per year
BLS Licensed Providers …	$300 per year	ALS Licensed Providers …….	$600 per year

Note: Dues must be paid at the rate for the highest level of licensure maintained by the provider. Providers who have operations bases in multiple counties must pay dues for each county. For questions regarding membership dues, please contact the ArAA Secretary at (870) 875-2273.

AFFIDAVIT OF MEMBERSHIP

By applying for membership with the Arkansas Ambulance Association, a 501c(6) not-for-profit corporation, I understand that acceptance of membership is subject to approval by the Board of Directors in accordance with the By-laws of the organization. I further understand that a portion of my membership dues may be used for direct lobbying expenses and, therefore, under IRS regulations, cannot be considered tax deductible. I certify that the above information is true and correct and that the ArAA may confirm such information with the Arkansas Department of Health, Office of EMS and Trauma Systems. I further understand that dues are paid on an annual basis and are not prorated. All memberships expire August 31 each year. Dues are non-refundable and non-transferable.

_____ _____

By/Title: Date

For Office Use Only: Payment Amount $ _____ Date Rec'd _____ Item No. _____