2016 Membership Application

Name____

Title____

Hospital Name____

Wk#____________________ Ext______ Fax# _______________________

Work Email_______________________ Home Email___________________

Hospital Address____

City/State/Zip____

Please indicate:

_______ CHAM certified ______ CHAA certified

______ Membership Renewal

______ First Time Member - How did you learn about NORTEX? (circle one)

- NORTEX flyer/email
- NORTEX member (Name______________________)
- NAHAM

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2015/2016 Renewal / Membership dues……………………………………………………………$50.00

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Please mail application & check (payable to NORTEX) to:

NORTEX
P.O. Box 202927
Arlington, TX 76006-2927