



2020 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

2019/2020 Renewal / Membership dues.....\$50.00

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

NORTEX
2131 N.Collins Ste 433 748
Arlington, TX 76011

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