



Company Name: _____

Primary Contact Person: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

Website: _____

Operating Since (Mo/Year): _____ Medicare Provider (Y/N): _____ Medicaid Provider (Y/N): _____

Medical Transportation Services Offered (check all that apply):

- MoICU, Air Ambulance, Basic Life Support, Nonemergency Transport, Advanced Life Support, Wheelchair

Please check the appropriate membership category:

Active Member (voting):

Any entity or authority engaged in the business of providing medical transportation licensed by the Ohio Medical Transportation Board and agreeing to abide by the bylaws of the Ohio Ambulance and Medical Transportation Association. Annual membership dues: \$315, plus per vehicle rate, based on number of ambulance, MoICU and wheelchair vehicles. Total amount of dues not to exceed \$4,000 for a single company.

Table with 3 columns: Description, Rate, Total. Rows include Licensed Ambulance Vehicles, Wheelchair/Ambulette Vehicles, MoICUs, Air Medical Unites, Base Membership Dues, and Total Payment.

Associate Member (non-voting):

All other entities in the business of providing medical transportation and agreeing to abide by the bylaws of the Ohio Ambulance and Medical Transportation Association. Annual membership dues \$435.

Flat Fee Membership Dues \$435

Please list any additional individuals you would like to receive Association communications on behalf of your organization.

Table with 3 columns: Name, Title, Email. Rows 1, 2, 3.

I understand that this application is subject to the approval of the Ohio Ambulance and Medical Transportation Association and that until it has been reviewed and acted upon, I understand that I shall be designated a Member-Applicant. Further, I understand that the first year's membership dues shall be payable at the time of this application, and that if for any reason this application is refused, the dues will be refunded in full. If elected to the membership, I pledge to conform to the articles, bylaws, code of ethics, professional standards and other official acts of the Ohio Ambulance and Medical Transportation Association.

Submitted by (authorizing agent) Title

Signature Date



Payment

Please select your preferred method of payment:

Check

Make checks payable to

“Ohio Ambulance and Medical Transportation Association”

155 East Broad Street, Suite 2020 Columbus, Ohio 43215

Visa

MC

Credit Card Number: _____

Cardholder Name: _____

Amount to be Charged: _____ Billing Zip: _____

Cardholder Signature: _____

OAMTA T.I.N. 34-6619511

Tax deductibility of membership dues: As a non-profit 501-C-6 tax-exempt trade association, dues to OAMTA may be deductible for federal income tax purposes as ordinary and necessary business expenses except for an amount that such dues are spent on lobbying activity.
