

MEMBERSHIP APPLICATION

TAAMS Texas Association of Air Medical Services

PO Box 15037
Galveston, TX 77555-5037
(409)-747-1237
(409)-772-3745 (FAX)

Tax ID # 45-7763074

INSTRUCTIONS FOR APPLICATIONS: ALL TAAMS MEMBERS MUST BE MEMBERS IN GOOD STANDING WITH NATIONAL AAMS.

Please type or print and fill in completely. Make a copy for your records, send original application with a check (payable to TAAMS) to TAAMS, PO Box 15037, Galveston, TX, 77555-5037.
Please call (409)-747-1237, if you have any questions.

MEMBERSHIP STATUS: See AAMS Brochure for further information regarding membership categories.

- | | | |
|--|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> Provider Member | \$750.00 per calendar year | <input type="checkbox"/> Renewal |
| <input type="checkbox"/> Associate Member | \$250.00 per calendar year | <input type="checkbox"/> New Member |
| <input type="checkbox"/> Individual Member | \$ 50.00 per calendar year | Year Program Started _____ |
| <input type="checkbox"/> Rotor Wing | <input type="checkbox"/> Fixed Wing | <input type="checkbox"/> Both |

PROVIDER MEMBERS: Each Provider will appoint a voting member.

Program Name: _____

Contact Person: _____ Title: _____

Mailing Address: _____ City: _____

State _____ Zip: _____ Business Phone: _____

Email Address: _____

FAX: _____ 24 hour non-emergency phone: _____

Voting Member: _____ Title: _____

Operation Information:

	<u>Rotor Wing</u>	<u>Fixed Wing</u>
Type of Aircraft:	_____	_____
Dedicated Aircraft (#):	_____	_____
1 RN	<input type="checkbox"/>	<input type="checkbox"/>
2 RN	<input type="checkbox"/>	<input type="checkbox"/>
1-2 PM	<input type="checkbox"/>	<input type="checkbox"/>
RN/PM	<input type="checkbox"/>	<input type="checkbox"/>
RN/MD	<input type="checkbox"/>	<input type="checkbox"/>
PM/MD	<input type="checkbox"/>	<input type="checkbox"/>
RN/RRT	<input type="checkbox"/>	<input type="checkbox"/>

Does your program hold its own Part 135? _____

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Associate Members

Name of Company: _____

Name of Contact Person: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Business Phone _____ FAX: _____

Email Address: _____

Description of Services: _____

Personal Members

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone _____ FAX: _____

Email Address: _____

Additional Contacts for Organization:

<u>Name</u>	<u>Phone</u>	<u>Email Address:</u>
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TAAMS Use Only:

Application Received: _____

Payment Received: _____ Check #: _____

Paid Through: _____

Status With National AAMS

AAMS Member

Provider

Associate

Personal