

 **POMAA** *Physician Office Managers Association of America*

Membership Application

Applicant's Name _____ Credentials _____
 First **MI** **Last**

Home Address _____
 Street **City** **State** **Zip Code**

Home Phone # _____ Cell # _____

Job Title and Position _____

Practice Information

Practice Name _____

Practice Specialty _____

Address _____
 Street **City** **State** **Zip Code**

Phone # _____ Fax # _____

Email Address _____

Where would you like your POMAA materials mailed? _____ **Work** _____ **Home**

Demographic Information

Highest Level of Education

_____ **High School** _____ **Associate Degree** _____ **Bachelors** _____ **Masters** _____ **Doctorate/PhD**

Number of years in the healthcare field

_____ **1-5** _____ **6-10** _____ **11-15** _____ **16-20** _____ **20+**

How did you hear about POMAA? _____

Referred by a friend or colleague, please tell us who: _____

Membership Type

_____ **Practice Manager \$129.00** _____ **Billing Manager/Specialist \$129.00** _____ **Student \$89.00**

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If you are applying for a student membership please answer the following questions:

Name of School _____
Address _____
Phone Number _____
Program of Study _____
Anticipated Date of Graduation _____ Current GPA _____
How many credits per term are you currently taking? _____

Membership Criteria

Individual membership requires that you are currently employed in a healthcare management roll. This includes office managers, practice managers, practice administrators, billing managers, front office supervisors, and other supervisor or manager positions in a medical practice setting.

Student membership requires that you are currently enrolled in a program such as healthcare administration, business administration, accounting, medical secretary, or any other business or healthcare related field. Student membership is for individuals that wish to enter the healthcare field in a medical office setting.

Membership Pledge

As a member of POMAA, I agree to demonstrate the dedication to gain knowledge in medical office management and to uphold the standards of the healthcare profession. I understand that my membership is non-transferrable and is valid for one year from the date my membership is activated.

Signature _____ Date _____

Credit Card Information (All information must be completed):

Credit Card Type: _____ Master Card _____ Visa _____ Discover _____ Amex

Card Holder's Name: _____
Last First MI

Credit Card Billing Address: _____
Street City State Zip Code

Credit Card Number: _____ Expiration Date: _____
MM/YY

CSC Number: _____

3 digit # on the back of a Visa or MasterCard

4 digit # on the front of an America Express Card

Please fax or mail this completed form to POMAA at the address or fax number listed below:

POMAA, P.O. Box 232, Dallastown, PA 17313
Phone: 1-877-782-5141 ~ Fax: 1-866-359-0561
memberships@pomaa.net ~ www.POMAA.net