



Application for Membership – NCAMES
North Carolina Association for Medical Equipment Services



(please fill out completely – application will be reviewed by the NCAMES Board of Directors)

Name of Company _____ Associate or Regular Member? _____

Company Contact Person _____ Title _____
 (This person will receive all NCAMES mailings)

Mailing Address _____

City/State/Zip _____ Phone _____

Fax _____ E-Mail _____ Web site _____

County in which main office is located: _____, Counties of service _____

of Locations _____ List cities (may use separate sheet) _____

Is your site accredited? _____ If so, by whom? _____ Year of first accreditation? _____

Are you licensed by the NC Board of Pharmacy? _____ Division of Facility Services (DFS) _____

Please check all that apply: _____ (1) DME Rental & Sales; _____ (2) Oxygen; _____ (3) Sales Rep/Mfr; _____ (4) Ostomy
 _____ (5) Orthotics; _____ (6) Pharmacy; _____ (7) Rehab; _____ (8) IV and/or PEN; _____ (9) Mastectomy; _____ (10) Consulting

Classify business type: ___ Free Standing, ___ Hospital Based, ___ Home Health Agency, ___ Hospice, ___ Pharmacy, ___ Rehab

PLEASE ANSWER THESE! Legislative Questions based on where company is located. If multiple sites, please attach list.
 (By completing this information, NCAMES will be able to communicate with them more efficiently when issues arise.)

Please list your Congressional District in Washington (1 through 13) _____

Have you developed a relationship with them? _____

Please list your State House District (1-98) _____ Have you developed a relationship with them? _____

Please list your State Senate District (1-42) _____ Have you developed a relationship with them? _____

OPTIONAL INFORMATION:

- Are you a member of: ___ AAHomecare, ___ NCSRC, ___ NCAHC, ___ NCPHA, ___ NARD, _____, NAIMES _____ Other
- Who invited you to join NCAMES? _____
- What do you expect to gain from your membership? _____
- ***Any other employees of your company may be included in our email broadcast:***

List their names & email addresses: _____

I wish to make an application to the North Carolina Association for Medical Equipment Services. As a member of NCAMES, I agree to comply with NCAMES' by-laws including strict adherence to all local, state, and federal laws. I have examined the above information and believe it to be accurate and complete.

Signed by officer of the Company _____

Print Name _____ Title _____ Date _____

Annual Membership dues for NCAMES are \$350 for regular (provider) or \$250 for associate (vendor). Additional sites are \$50 each. Dues must be current to attend NCAMES meetings at member rates. Please submit payment by check or credit card with completed applications to the address below.

Join the industry leaders in North Carolina, join NCAMES today!!
NCAMES, PO Box 4411, Cary, NC 27519-4411
Phone (919) 387-1221, Fax (919) 387-4255
e-mail: NCAMES@nc.rr.com, web site: www.ncames.org



INVOICE



NCAMES MEMBERSHIP RENEWAL - 2010

NCAMES needs you and you need NCAMES – don't let your membership expire!

We value your membership and want to continue our partnership!

NCAMES, Beth Bowen, Executive Director, PO BOX 4411, Cary NC 27519-4411

Through the determined effort and commitment of NCAMES staff and members we have:

- ◆ DISCOUNTED QUALITY EDUCATION FOR NCAMES MEMBERS
- ◆ Become very active in National Competitive Bidding political and grassroots efforts
- ◆ Strengthened our lobbying efforts on legislative issues – like delaying Competitive Bidding and Oxygen Reform!
- ◆ Worked closely with Medicaid to protect providers and patients during budget crisis
- ◆ Continued a working dialogue with Payors
- ◆ Improved our e-mail communication network, thus enabling us to quickly notify members of critical issues and changes
- ◆ Renewed our commitment to promoting the concerns of the DME industry
- ◆ Continually held successful meetings and trade shows, which include many HME vendor exhibits and quality speakers
- ◆ Regularly update members on regulatory and other issues that pertain to the industry

2010 DUES PAYMENT INFORMATION:

2010 Membership Level – Associate (Vendor) Member

*** \$250.00 (Plus \$50 per location)**

*** Annual Vendor sponsor programs available for levels between \$1000 - \$4000.**

*** Sponsorships include membership dues, summer exhibit space AND many other benefits!! See website for details!**

After payment is received, your dues will be current through December 31, 2010

You are NCAMES. Your association has become a well-respected voice to state and federal officials. Separately, we are barely heard. Together our voice is loud and strong and it makes a difference. Now that our industry is facing more challenges than ever, it is more important than ever to support your industry TODAY and you're your state association. Watch for more exciting opportunities to become involved! Up to 20% can be used for lobbying purposes.

Mail To:

NCAMES - Beth Bowen, Executive Director

PO BOX 4411, Cary, NC 27519-4411

Phone: 919 387-1221; Fax 919 387-4255

Thank you in advance. If you have any questions, please call the NCAMES office at 919 387-1221. We hope to see you at the next meetings in **2010**: Winter Meeting & Legislative Conference - **January 21-21** at the Grandover Resort in Greensboro and the Summer Meeting and Exhibit Show – **June 23-25** at the Holiday Inn Resort Wrightsville Beach!

Sincerely,

Beth Bowen

Beth Bowen, Executive Director, NCAMES

November 1, 2009



NC Association for Medical Equipment Services
P.O. Box 4411, Cary, NC 27519-4411
Phone: (919) 387-1221, Fax: (919) 387-4255
www.ncames.org

"Serving the industry leaders in North Carolina"

CREDIT CARD CHARGE AUTHORIZATION FORM – FAX to 919-387-4255

The credit card form must be filled out completely, or payment will be declined and not processed.

Date: _____

Member type: Regular or Assoc. _____

Business Name: _____

Contact Name: _____

Phone Number: _____

E-mail Address: _____



(CIRCLE CARD TYPE or write choice here _____)

CREDIT CARD NUMBER: _____

EXPIRATION DATE: _____

V-Code (3 digits) _____

(Back of card, Amex is 4-digit code on front of card)

Name on Credit Card: _____

Billing Address of Credit Card: _____

Charge Amount \$ _____ Item Purchased: _____

Cardholder's Signature: _____