

## **Active and Associate Membership Renewal Form**

We are asking that all information for your practice be filled in completely so this can be checked in the database for accuracy. Please submit your renewal application and dues no later than March 1, 2021.

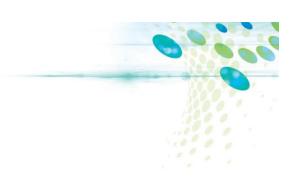
Renewal of membership dues is \$150 for the Active member (only one Active member per practice) and \$35 per Associate member annually. Please make your check payable to POHMS and mail to:

POHMS' Member Services 1802 State Route 31, #312 Clinton, NJ 08809

## **PRACTICE INFORMATION:**

Practice Name			
City	State Zip/Postal Code		
County			
Phone ()	Fax ()		
Total Practice Employees:	Total # of RN's:		
How Long Practice in Existence?	Total # of Physician Extenders:		
Physicians: Please list			
Physicians: Please list			





Satellite #2:	
Satellite #3:	

Please list any additional satellite offices on a separate page and attach to the application.





## Active Member Information (Please type or print clearly.)

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Name		Last	
Title/Position	ı:		
Please indica	te:		
MD	PhD	Email Address:	
PharmD	BA		
RN	MSN		
MS	BS		
Other			
	В		

## $\boldsymbol{Associate\ Member\ Information}\ (\textbf{Please\ type\ or\ print\ clearly.})$

Name				
First	Last			
Title/Position:				
Email Address:				
Additional Associate Members, Name, Title and email addresses				