

CALIFORNIA MEDICAL TRANSPORTATION ASSOCIATION, INC. – CMTA

11647 MORRISON STREET
NORTH HOLLYWOOD, CA 91601
818-766-2682
WWW.CMTASITE.COM

APPLICATION FOR MEMBERSHIP

Company Information: **Application Date:** _____

Name* _____

Address* _____

Mailing Address _____

Telephone* _____ Fax* _____

Service Area (counties)* _____ Fed. Tax Id* _____

Number of Vehicles in Operation* _____ Level of Service:* ADD W/C Gurney
 BLS ALS SCT

CMTA Dues: (will be charged to Credit Card on the first of each month, **Credit Card on file is required**)

Monthly \$ 200.00 / month **Annually** \$2,160.00 (if paid in one installment in advance) – 10% discount applied

Principal Contact:

Name* _____ Title* _____ E-mail* _____

Secondary Contact:

Name _____ Title _____ E-mail _____

A \$300.00 (\$100 application fee and \$200 first month dues) must accompany this form.

Please make check payable to **CMTA.**
Mail completed form to: **11647 MORRISON STREET**
NORTH HOLLYWOOD, CA 91601

By signing this application I agree for one year commitment (required for approval)

Authorized Representative Name* _____ Signature* _____