

Western Pennsylvania Health Information Management Association (WPHIMA)

Membership Application-JANUARY - DECEMBER 2010

DEMOGRAPHICS

FIRST NAME: _____

LAST NAME: _____

HOME ADDRESS: _____

CITY: _____

STATE: _____ ZIP CODE: _____

HOME PHONE: () _____

COMPANY NAME: _____ TITLE: _____

WORK ADDRESS: _____

CITY: _____

STATE: _____ ZIP CODE: _____

WORK PHONE: () _____

EXTENSION: _____

FAX NUMBER: () _____

HOME PHONE: _____

PREFERRED MAILING ADDRESS: WORK HOME EMAIL ADDRESS: _____

AREA(S) OF SPECIALTY

ACUTE CARE

DRUG/ALCOHOL REHABILITATION

NON-TRADITIONAL SETTING

AMBULATORY CARE

EDUCATION

OTHER (SPECIFY)

BEHAVIORIAL HEALTH

EHR/EMR/INFORMATION SYSTEMS

PHYSICIAN OFFICE

CODING (SPECIFY-InPat,Outpt,ICD-9,CPT-4)

HIPAA

TRANSCRIPTION

CONSULTING

LONG-TERM CARE

TUMOR REGISTRY

CREDENTIALS: (CHECK ALL THAT APPLY)

RHIA RHIT CTR CMT CCS MS MBA CPHQ PhD MPM

STUDENT OTHER

MEMBERSHIP TYPE

(Please Check One)-FEE for Active and Associates \$10; Student \$5. Enclose check to WPHIMA with this application.

ACTIVE: Any individual with an AHIMA certification, i.e. (RHIA, RHIT, CCS, etc.)

ASSOCIATE: Any individual presently or formerly engaged in the health field who does not qualify for Active Membership.

STUDENT: Any student residing in Western PA and is enrolled in an approved school for health information personnel is eligible.

RETIRED: Any individual with an AHIMA certification retired from the healthcare field in Western PA - EXEMPT FROM DUES.

PLEASE CHECK THE FOLLOWING BOXES:

I wish to be included in outside mailings for vendors, recruiters, healthcare facilities, etc.

I am interested in serving as a WPHIMA volunteer leader (committee chair, member, or officer)

I have access to the Internet and email.

I allow my information to be released to fellow members for networking purposes.

Mail application and check to Laurie M. Johnson, MS, RHIA, CPC-H, 114 Knollwood Drive, Sarver, PA 16055

* If receipt is required, please make a copy of the application prior to sending.