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)* ____

Number of Vans in Operation* _______ Level of Service:* ❑ **ADD** ❑ **W/C** ❑ **Gurney** ❑ **BLS** ❑ **ALS** ❑ **SCT**

CMTA Dues: (will be billed on monthly, quarterly or annual basis)

❑ **Monthly** $ 150.00 / month
❑ **Quarterly** $ 450.00 / quarter
❑ **Annually** $1,620.00 (if paid in one installment in advance) – 10% discount applied

Principal Contact:

Name* ______________________ Title* ____________ E-mail* _______________________

Secondary Contact:

Name ______________________ Title ____________ E-mail _______________________

A $ 100.00 (one hundred dollars) application fee 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* ______________

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