(Please type or print)

SOUTH FLORIDA HEALTH INFORMATION MANAGEMENT ASSOCIATION

2020 MEMBERSHIP APPLICATION

DATE : _____

NAME: _____
(Name Change: When applicable, please include previous name.)

CREDENTIALS: ❑ RHIA ❑ RHIT ❑ CCS ❑ CCA ❑ CPC
❑ STUDENT ❑ *OTHER (Specify)*
_____

Are you a member of AHIMA? ❑ Yes ❑ No **If Yes, provide member ID #**_____

If student, provide name of school: _____

HOME ADDRESS: _____
(Street)

_____
(City) *(State)* *(Zip Code)*

HOME PHONE: (_____) _____ **BUSINESS PHONE:** (_____) _____

E-MAIL ADDRESS: _____
Print clearly please, we will be using your email to communicate important information

NAME OF EMPLOYER: _____

JOB TITLE: _____

BUSINESS ADDRESS: _____
(Street) *(City)* *(State)* *(Zip Code)*

_____
(Please select one) **SEND MAIL TO:** ❑ HOME ADDRESS ❑ BUSINESS ADDRESS ❑ E-MAIL ADDRESS

MEMBERSHIP STATUS: ❑ **NEW MEMBER** ❑ **RENEWAL**

MEMBERSHIP DUES: **ONE YEAR** (January – December)
- **$35.00 for:** ❑ **Active** ❑ **Corporate (per person)**
- **$20.00 for:** ❑ **Student**

Make check payable to:
South Florida Health Information Management Association (SFHIMA)

Return your check and completed application to:
Mary Worsley, SFHIMA Treasurer
PO Box 900862
Homestead, FL 33090