MEMBERSHIP APPLICATION FORM

Company Information

Company Name _____
Main Location Address _____
City, State, Zip _____ Phone # _____
Website Address _____ Fax # _____
Primary Contact _____
Email Address _____
Alternate Contact _____
Email Address _____
Year Company Founded or Years in HME Business _____

Branch Locations (use reverse side for additional locations)

Address #1 _____ Phone #_____
City, State, Zip _____ Fax #_____
Address #2 _____ Phone #_____
City, State, Zip _____ Fax #_____

Ownership Structure

Our Company is:
(check all that apply)

____Independently Owned
____Hospital Affiliated
____Publicly Held
____Subsidiary of Parent Corporation
____Other (Joint Venture, etc).

Scope of Service

Traditional Home Medical Equipment	% of Total Service: _____
Respiratory Services	% of Total Service: _____
Sleep Services	% of Total Service: _____
Rehab & Assistive Technology	% of Total Service: _____
Supplies	% of Total Service: _____
Enteral Services	% of Total Service: _____
Pharmaceutical Services/Infusion	% of Total Service: _____
Other	% of Total Service: _____

Annual Gross Volume in Revenue $_____

Staffing

Number of Full Time Employees: _____

Does your company employ the following:

Respiratory Therapists #____ ATPs #_____
OT/PT #____ Rehab Techs #_____
Other #____

Industry Involvement

Are you or any of your staff involved in the following organizations? (check all that apply)

____American Association for Homecare (AAH)
____State Association
____NRRTS
____AARC
____AASM
____RESNA
____NHIA

Other organizational affiliation and/or consumer advocacy groups?

_____

_____

Are you a member of any Buying Group? _____Yes _____ No
If yes, please list: _____

Accreditation

Select appropriate accreditation status: ___JCAHO ___CHAP____ACHC___HQAA___Other(list)_____
Comments: _____

Most Important Issues That Affect Your Financial Performance

__Reimbursement
__Supply Costs
__Networking
__Repairs
__Benchmarking
__Accreditation
__Education/CEUs
__Business Financing
__Best Practices
__Staffing
__Operations
__Managed Care
__Talent Management
__Regulatory
__Competitive Bidding

Supplier Volume

List in descending order your five largest suppliers:	Estimated Annual Volume
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

MED Referral

How did you hear about MED? What interests you about MED Membership?

_____

_____

Please fax to 866-230-7771, Attn: Membership

By completing the signature portion below, "Applicant" authorizes The MED Group to obtain and use background information and consumer credit reports that may be necessary to evaluate this application. This process and the information utilized could result in the denial of the application. "Applicant" also expressly authorizes The MED Group to contact any third parties, including appropriate suppliers, to obtain information about "Applicant's" accounts and payment histories. "Applicant" waives any right or claim that might be otherwise held under the Fair Credit Reporting Act. "Applicant" releases and indemnifies The MED Group from any liability resulting from acquiring and using such information. I hereby attest, by signature below, that I am authorized to complete this form for my company.

_____
Applicant-MED Membership Candidate

_____ _____
Company Date

02.21.13jrg