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**Membership Contact Form**

***Please type or print clearly***

Information provided will only be shared with CATRAC staff and CATRAC members for business and emergency purposes.

|  |  |  |
| --- | --- | --- |
| Agency Name: | | |
| Service Type: | | |
| Website URL: | | County: |
| Physical Address: | | |
| Mailing Address: | | |
| Main Office Phone: | Fax: | |

Please complete the following and include each contact’s NAME, EMAIL and PHONE**.**

|  |  |  |  |
| --- | --- | --- | --- |
| **24/7 contact for CATRAC to use for emergency notifications of incidents or events:** | | | |
| Name: | Email: | Office Phone: | Cell Phone: |
| Contact for routine information or business questions: | | | |
| Name: | Email: | Office Phone: | Cell Phone: |
| General Membership **DESIGNATED** CATRAC Voting Member:  (Designated voting member **or** alternate voting member are required to attend 75% of General Membership meetings) | | | |
| Name: | Email: | Office Phone: | Cell Phone: |
| General Membership **ALTERNATE** CATRAC Voting Member:  (Designated voting member **or** alternate voting member are required to attend 75% of General Membership meetings) | | | |
| Name: | Email: | Office Phone: | Cell Phone: |
| Agency Director / Administrator: | | | |
| Name: | Email: | Office Phone: | Cell Phone: |
| Operations Director: | | | |
| Name: | Email: | Office Phone: | Cell Phone: |
| Medical Director: | | | |
| Name: | Email: | Office Phone: | Cell Phone: |
| Performance/Quality Improvement Coordinator (PI/QI): | | | |
| Name: | Email: | Office Phone: | Cell Phone: |
| Designated Infection Control Officer: | | | |
| Name: | Email: | Office Phone: | Cell Phone: |
| Contact to Receive Regional Class/Training Information: | | | |
| Name: | Email: | Office Phone: | Cell Phone: |

**CATRAC COMMITTEES:**

*Below are the official Committees as outlined in the CATRAC Organizational Bylaws. Participation in at least one committee is expected of all member agencies. Participation on more than one committee is greatly encouraged to help bring a multi-disciplinary approach to the committees.*

* Please include **NAME, EMAIL and PHONE** for each committee participant.
* You may add more than one person per committee.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Pre-Hospital Committee: | | | | | | |
| Name: | | Email: | Office Phone: | | Cell Phone: | |
| Education Committee: | | | | | | |
| Name: | | Email: | Office Phone: | | Cell Phone: | |
| Trauma Systems & Operations Committee: | | | | | | |
| Name: | | Email: | Office Phone: | | Cell Phone: | |
| Injury Prevention Committee: | | | | | | |
| Name: | | Email: | Office Phone: | | Cell Phone: | |
| Stroke Committee: | | | | | | |
| Name: | | Email: | Office Phone: | | Cell Phone: | |
| Cardiac/Mission Lifeline: | | | | | | |
| Name: | Email: | | | Office Phone: | | Cell Phone: |
| Regional Preparedness & Response Committee and Capital Area Public Health & Medical Preparedness Coalition Representative: | | | | | | |
| Name: | | Email: | Office Phone: | | Cell Phone: | |

Please complete the following for CATRAC membership renewal**.**

|  |  |  |
| --- | --- | --- |
| **Billing Address:** | | |
| **Accounts Payable Department Contact:** | | |
| Name: | Email: | Office Phone: |

**Application Approved By:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Administrator or Director signature) (Date)

This form should be signed and forwarded to the administrative coordinator, Melissa Hamaker, at 512-926-2777 (fax) or email at [mhamaker@catrac.org](mailto:mhamaker@catrac.org). This form can be downloaded at www.catrac.org