PAAHCR
Philadelphia Area Association of Health Care Recruiters
WWW.PAAHCR.COM

APPLICATION FOR MEMBERSHIP

Name: _____ Suffix (RN, etc.): _____

Position: _____

Institution/Company Name: _____

Address: _____

Telephone Number: _____

Fax Number: _____

E-Mail Address: _____

Amount Paid: _____ Check Number: _____ Date: _____
(membership is for (1) Year from date paid)

Membership: ❑ New ❑ Renewal

Membership Type:

- ❑ Active ($60.00)
- ❑ Associate ($100.00)
- ❑ Institutional ($250.00)

Send Check to:
PAAHCR
c/o Louisa Groh, PAAHCR Treasurer
Supplemental Health Care
321 Norristown Road, Suite 220
Ambler, PA 19002

Please complete the following confidential information for PAAHCR records:

1. Are you a NAHCR member? Yes ❑ No ❑

2. Highest degree obtained _____

3. Number of years as a recruiter _____

4. Are you ❑ Full-time or ❑ Part-time

5. Please list the areas that you recruit for:

_____

_____

Thank you. We will notify you once your membership is active.