CALIFORNIA MEDICAL TRANSPORTATION ASSOCIATION, INC. – CMTA

2168 MOONBROOK CIR
ROSEVILLE, CA 95747
818-766-2682
WWW.CMTASITE.COM

APPLICATION FOR MEMBERSHIP

Company Information: **Application Date: _____**

Name* _____

Address*_____

Mailing Address _____

Telephone*_____ Fax*_____ NPI*_____

Service Area (counties)*_____ Fed. Tax Id* _____

Number of Vehicles in Operation* _____ Level of Service:* ❑ **ADD** ❑ **W/C** ❑ **Gurney** ❑ **Ambulatory**

CMTA Dues: (will be charged to Credit Card on the first of each month, **Credit Card on file is required**)

❑ **Monthly** $ 150.00 / month ❑ **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 $250.00 ($100 application fee and $150 first month dues) must accompany this form.

Please make check payable to **CMTA.**
Mail completed form to: **2168 MOONBROOK CIR**
ROSEVILLE, CA 95747

By signing this application I agree for one year commitment (required for approval)

Authorized Representative Name*_____ Signature*_____

Rev. 7/1/2024