

CENTRAL NEW YORK HEALTH INFORMATION MANAGEMENT ASSOCIATION
MEMBERSHIP YEAR JULY 2008 – JULY 2009
MEMBERSHIP FORM

Please remember that in order to qualify for the discounted member rate at CNYHIMA meetings your dues must be current!

NAME: _____

RHIA RHIT CCS CCS-P CHP OTHER _____

TITLE: _____

PRIMARY WORK SETTING: Acute Care Long Term Care Educator
 Ambulatory Care Ancillary Vendor Other _____

**PREFERRED
MAILING
ADDRESS:**

EMAIL: _____

BUSINESS TELEPHONE: _____

HOME TELEPHONE: _____

Please help CNYHIMA save on postage costs by sending information via Email only _____

GEOGRAPHICAL PREFERENCE FOR MEETINGS: _____

TOPIC SUGGESTIONS: _____

SPEAKER SUGGESTIONS: _____

DUES: The dues of this Association shall be ten dollars (\$10.00) per year for Active, Associate, Inactive, Supporting and Other members. (*Asterisked membership categories do not have dues)

Active Associate Inactive Supporting Student* Honorary*
 Other _____

I would be interested in participating in the following activities:

Officer Bylaws Committee Education/Program Committee Public Relations
 Nominating Credentials/Membership Other (specify): _____

Make checks payable to CNYHIMA and return with this form to:

Ruth Smith, RHIA
322 Winton Street
Syracuse, NY 13203

Thank you for your support!!!!