



Annual Membership Application

Name: _____

Credentials: CPHQ RN LPN RHIA RHIT Other

Title: _____

Business Phone: () _____

Home Phone: () _____

Organization: _____

Business Address: _____

City: _____ State: ____ Zip: _____

FAX: () _____

E-mail address: _____

Are you a member of NAHQ? Yes / No

Send more information on: NAHQ Membership / CPHQ Program

Signature: _____

(Please include dues of \$45/one year)

Make checks payable to WAHQ and mail to:

Gloria Field
3740 River Drive
Plover Point, WI 54467