CALIFORNIA CENTRAL SERVICE ASSOCIATION

Affiliated chapter of the International Association of Healthcare Central Service Materiel Management

MEMBERSHIP APPLICATION AND RENEWAL FORM

(*Please PRINT or TYPE Information*)

Date: _____

EVERYONE must complete this information.

(Circle one:) Mr./Ms./Mrs.	FIRST NAME	MIDDLE INITIAL	LAST NAME
HOME ADDRESS:			AREA CODE/PHONE NUMBER ( )
HOME CITY	STATE	ZIP CODE	E-MAIL ADDRESS
POSITION TITLE:			
HOSPITAL/FIRM NAME			
BUSINESS ADDRESS			
BUSINESS CITY	STATE	ZIP CODE	
BUSINESS COUNTY			AREA CODE/PHONE NUMBER/EXTENSION ( )

LAST FOUR DIGITS OF SOCIAL SECURITY #:	YRS. IN CS FIELD:	PREVIOUS CCSA MEMBER? (*Please ✓ one*) ( ) YES ( ) NO

PLEASE SEND ALL CORRESPONDENCE TO MY (✘ *one*): ( ) HOME ( ) BUSINESS

ADDITIONAL MEMBER INFORMATION

LICENSE(S) AND CERTIFICATION(S): (*Please include license type [i.e., LVN, RN, etc.] and number(s)*

IAHCSMM MEMBER NUMBER: **CRCST** **RCST** **(circle classification level)**

PAYMENT INFORMATION:

Make checks or money orders payable to: **CCSA**

Mail to: CCSA c/o Marilyn Conde
3303 South Archibald Ave. Apt. 101.
Ontario, Ca 91761

(A service fee of $10.00 will be charged for all returned checks.)
Membership fees are non-refundable

Membership fees: Annual Membership or Renewal **$25.00** (April to April)
Membership fee waived when non-member fee paid for a CCSA seminar

SEMINAR ATTENDANCE DATE & CITY: _____

Visit us on the Internet: **www.ccsa1.org**

OFFICE USE ONLY: **New Member**: ( ) **Returning Member:** ( ) **Renewal**: ( )

MEMBER #	REG. #	DATE PD.	AMT. PD.	CHECK #	RECEIPT #	EXPIRES	PKG. SENT	DATA ENTRY

Revised: 11/4/10