



Ohio Association of Critical Care Transport  
Membership Application  
2014

Voting member \_\_\_\_\_ \$200 (Must be a full member of AAMS)

Name of Program: \_\_\_\_\_

Types of Services: (Circle all that apply)    RW    FW    MICU

Company: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State: \_\_\_\_\_

Zip: \_\_\_\_\_

Emergency Phone: \_\_\_\_\_

Administrative Phone: \_\_\_\_\_

FAX: \_\_\_\_\_

E-mail: \_\_\_\_\_

Program Administrative Contact: \_\_\_\_\_

Medical Crew – Clinical Supervisor: \_\_\_\_\_

Communications/ \_\_\_\_\_

Dispatch Supervisor:

Medical Director:

Aviation Manager:

Other Key personnel  
And titles:

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**Base of Operations**

Type	Location	Hours	Type	Location	Hours
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

**Specialty Transports**

Type	Mode	Comments/Special Instructions
IABP		
VAD		
NICU		
Prisoners		
Hazmat Response		
Organ procurement		
Other		

**RW/FW Only**

Aircraft type	Color	N#	Patient # capability	IFR	Family can accomodate


Please list below appropriate personnel from your program that will be attending meetings and should be listed on group email for meeting minutes distribution.

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_ Email \_\_\_\_\_

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_ Email \_\_\_\_\_

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_ Email \_\_\_\_\_

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_ Email \_\_\_\_\_

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_ Email \_\_\_\_\_