



JAMES

Keeping Members Informed

PO Box 38 • Jackson, NJ 08527 • 732-503-5665
www.jamesofnj.org

ASSOCIATE MEMBERSHIP APPLICATION

ASSOCIATE MEMBERSHIP CLASSIFICATION: A PERSON OR ENTITY NOT OTHERWISE QUALIFIED FOR GENERAL MEMBERSHIP THAT ENGAGES, THROUGH MANUFACTURING, WHOLESALE, OR OTHERWISE IN A BUSINESS THAT SUPPORTS OR ENHANCES A GENERAL MEMBER'S HEALTH CARE BUSINESS.

COMPANY INFORMATION

COMPANY NAME (please print clearly on above line)

DOING BUSINESS AS

NAME OF COMPANY PRESIDENT OR CEO

EMAIL ADDRESS

ADDRESS

CITY

STATE

ZIP

PHONE

FAX

E-MAIL

ARE YOU A SUBSIDIARY OF ANOTHER COMPANY? Yes No

IF YES, PLEASE PROVIDE THE FOLLOWING INFORMATION:

PARENT COMPANY NAME

NAME OF PRESIDENT OR CEO

ADDRESS OF PARENT COMPANY

CITY

STATE

ZIP

PHONE

FAX

E-MAIL

DO YOU HAVE ANY BRANCH LOCATIONS? Yes No

IF YES, PLEASE PROVIDE THE FOLLOWING INFORMATION:

BRANCH - COMPANY NAME

BRANCH MANAGER

ADDRESS

CITY

STATE

ZIP

PHONE

FAX

E-MAIL

CONTACT INFORMATION

PLEASE PROVIDE THE ASSOCIATION WITH A CORPORATE OFFICE CONTACT AND A LOCAL NEW JERSEY REPRESENTATIVE CONTACT:

CORPORATE OFFICE CONTACT NAME

PHONE

FAX

E-MAIL

NEW JERSEY CONTACT NAME

PHONE

FAX

E-MAIL

ADDITIONAL CONTACT NAME

PHONE

FAX

E-MAIL

PLEASE SELECT WHICH CONTACT WE SHOULD ADD TO OUR MASS EMAIL AND FAX LISTING. THESE INDIVIDUALS WILL RECEIVE ALL INFORMATION THAT IS PUBLISHED BY JAMES:

- CORPORATE OFFICE CONTACT NEW JERSEY REPRESENTATIVE CONTACT
- ADDITIONAL CONTACT

PLEASE SELECT TYPE OF BUSINESS:

- MANUFACTURER DISTRIBUTOR/WHOLESALE OTHER: (Please specify) _____

PLEASE SELECT ALL PRODUCT CATEGORIES THAT APPLY TO YOUR BUSINESS:

- DME OXYGEN/RESPIRATORY PHARMACY MEDICATIONS MEDICAL SUPPLIES
- PROSTHETICS/ORTHOTICS REHABILITATION PRODUCTS INFORMATION TECHNOLOGY/SOFTWARE
- OTHER: (Please specify) _____

ASSOCIATE MEMBERSHIP DUES

ANNUAL MEMBERSHIP DUES FOR ASSOCIATE MEMBERS ARE \$850. DUES FOR ASSOCIATE MEMBERS INCLUDE ONE BOOTH AND ONE COMPANY REPRESENTATIVE AT THE ANNUAL CONFERENCE. **A PAYMENT IN THE AMOUNT OF \$425 MUST ACCOMPANY ALL APPLICATIONS FOR ASSOCIATE MEMBERSHIP.** APPLICATIONS FOR MEMBERSHIP ARE REVIEWED BY THE BOARD OF DIRECTORS ON A MONTHLY BASIS. ONCE THE APPLICATION FOR MEMBERSHIP IS REVIEWED, THE MEMBER WILL BE CONTACTED FOR PAYMENT OF THE REMAINING DUES BALANCE.

PAYMENT

- CHECK ENCLOSED VISA MASTERCARD AMERICAN EXPRESS

CARD NUMBER: _____ EXPIRATION DATE: _____

NAME ON CARD: _____ SECURITY CODE: _____

ADDRESS OF CARDHOLDER _____

SIGNATURE: _____

CERTIFICATION

BY THE SIGNATURE AFFIXED BELOW, I HEREBY CERTIFY THAT THE INFORMATION SUBMITTED IN THIS APPLICATION IS TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTOOD THE JAMES CODE OF ETHICS AND AGREE TO CONDUCT MY BUSINESS IN ACCORDANCE WITH ITS PRINCIPLES. I ALSO UNDERSTAND THAT MY MEMBERSHIP IN JAMES MAY BE TERMINATED FOR FAILURE TO COMPLY WITH THE PRINCIPLES ENUMERATED IN THE CODE OF ETHICS.

JAMES RESERVES THE FOLLOWING RIGHTS: TO DENY ANY MEMBERSHIP APPLICATION; TO NOT RENEW A MEMBERSHIP; AND TO TERMINATE ANY MEMBERSHIP FOR THE CAUSE IN ACCORDANCE WITH THE PROCEDURES CONTAINED IN THE JAMES BYLAWS.

AUTHORIZED SIGNATURE OF APPLICANT: _____

DATE: _____

<p>Referred for Membership by:</p> <p>_____</p>
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RETURN THIS FORM BY MAIL OR FAX:

JAMES
Attn: Membership
PO BOX 38
Jackson, NJ 08527

Phone 732.503.5665 Fax 732.833.2029

<p>For Office Use Application Status:</p> <p>Date: _____</p> <p>_____</p>
