



Membership Application

Fax to: 972.719.4009 or Email to membership@dfwhc.org

Hospital Name: _____

Contact Information:

Main Phone Number:(_____) _____ Fax:(_____) _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Physical Address: Please Check here if it is the same as above: ____

Address: _____

City: _____ State: _____ Zip: _____

Website: _____

Chief Executive Officer/President Contact information:

Name: _____ Preferred Title: _____

Phone Number:(_____) _____ Fax:(_____) _____

Email: _____

Assistant's Name: _____

Phone Number:(_____) _____ Email: _____

Hospital Information:

Class Membership Applying for: ____ Class I ____ Class II ____ Class III

Is the hospital a member of a system (yes/no): _____ If yes, which one: _____

Patient days: _____ Adjusted patient days: _____

Number of beds: _____ Number of outpatient visits: _____

Is this a specialty hospital (yes/no): _____ If yes, what is the specialty: _____

Number of employees (at this location): _____ Number of locations (i.e. clinics): _____

Area served: _____ Status : _____
(Investor owned, private, if affiliated with a religion, please list)

Additional Information:

Reason for wanting to be a member: _____

How did you hear about DFWHC: _____

Please attach a list of your current Board of Trustees.

For Internal Use:

Board Date: _____ Approved/Not Approved: _____

Date notice of status was sent out: _____