



Texas Organization of Rural & Community Hospitals

HOSPITAL MEMBERSHIP APPLICATION

Date: _____

Hospital Name _____

Administrator Representing Hospital _____

Street Address _____ Zip _____

Mailing Address _____ Zip _____

City _____ County _____

Telephone # _____ Fax # _____ E-Mail _____

Ownership/Type Categories: (check applicable category below)		Number of Licensed Beds _____	
<input type="checkbox"/> Governmental/Public		Number of Staffed Beds _____	
<input type="checkbox"/> District: Supported by a local hospital district		DSHS Region/Zone _____	
<input type="checkbox"/> Authority: Supported by a local hospital authority			
<input type="checkbox"/> City: Supported by the city			
<input type="checkbox"/> County: Supported by the county			
<input type="checkbox"/> Not-for-Profit (_____ church-related; _____ other, including NFP Corp)			
<input type="checkbox"/> For-Profit (_____ investor-owned; _____ corporation; _____ partnership)		Yes	No
Management Type: (check applicable)		JCAHO Certified? _____	
<input type="checkbox"/> Independent Administration		Does hospital have:	
<input type="checkbox"/> Corporate: Part of a larger system		Rural Health Clinic? _____	
<input type="checkbox"/> Managed: Operated by an outside company		Home Health Care? _____	
<input type="checkbox"/> Leased: Under an ownership agreement		Designation:	
By _____		Sole Community? _____	
		Medicare Dependent? _____	
		Critical Access? _____	

General acute care hospital less than 150 beds in size

Dues Categories:

A. Annual Gross Revenue
Less than \$10 million: \$1500

B. Annual Gross Revenue
\$10 to \$50 million: \$2500

C. Annual Gross Revenue
More than \$50 million: \$3000

Membership Fee Enclosed: \$ _____

Dues Year: January 1 - December 31

Make check payable to TORCH; Mail to P. O. Box 14547, Austin, Texas 78761

March 2009

For TORCH Use: Approved: _____ Certificate Sent: _____
