As a TORCH Hospital Member,
You will have exclusive access to an array of rural health care resources, services, programs, tools and opportunities to assist you in your current position and future health care career endeavors, including:

- Advocacy and representation,
- Useful and timely information,
- Resource documents and publications,
- Opportunity to use the TORCH logo in marketing materials,
- Potential for marketing opportunities at other conferences or meetings,
- Educational programs designed specifically for rural and community hospitals,
- And more!

**Ownership/Type Categories:** (check applicable category below)

- Governmental/Public
  - District: Supported by a local hospital district
  - Authority: Supported by a local hospital authority
  - City: Supported by the city
  - County: Supported by the county
- Not-for-Profit
  - Church-related
  - Other, including NFP Corp
- For-Profit
  - Investor-owned
  - Corporation
  - Partnership

**Number of Licensed Beds** _________________________

**Number of Staffed Beds** _________________________

**DSHS Region/Zone** _____________________________

**Management Type:** (check applicable category below)

- Independent Administration
- Corporate: part of a larger system
- Managed: operated by an outside company
- Leased: Under an ownership agreement

By: ____________________________________________

**JCAHO Certified?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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**Does hospital have:**

<table>
<thead>
<tr>
<th>Rural Health Clinic?</th>
<th>Home Health Care?</th>
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**Designation:**

<table>
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<tr>
<th>Sole Community?</th>
<th>Medicare Dependent?</th>
<th>Critical Access?</th>
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TORCH Hospital Membership & Payment Form

Hospital Name: ________________________________

Administrator Name: ________________________________

Email: __________________________________________

Street Address: ______________________________________

City: __________________________ State: __________ ZIP: __________

Mailing Address: ______________________________________

City: __________________________ State: __________ ZIP: __________

Phone Number: __________________ Fax Number: __________

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Hospital (in state) General acute care hospital, less than 150 beds in size

A. Annual Gross Revenue
   Less than $10 million: $1,895

B. Annual Gross Revenue
   $10 to $50 million: $3,085

C. Annual Gross Revenue
   More than $50 million: $3,850

Membership Fee Enclosed: __________________________

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DUES YEAR: JANUARY 1 – DECEMBER 31

Make check payable to: TORCH. Mail to 3309 Forest Creek Dr., Unit 305,
Round Rock, Texas 78664-6168 — OR — Use the credit card form below

Today’s Date: ______________ Amount Enclosed: ______________ Check Enclosed: ❑


Credit Card Number: ________________________________

Company Name: ________________________________

Person Authorized to Charge: __________________________

Signature Authorizing Charge: ________________________________

Billing Address: ________________________________

City: __________________________ State: __________ ZIP: __________

Email Address: ________________________________

Phone: ________________________________