



GAOE MEMBERSHIP REGISTRATION

NAME AND TITLE: _____

PRACTICE NAME: _____

MAILING ADDRESS: _____

PHONE NUMBER: _____ FAX NUMBER: _____

WORK E-MAIL: _____

NUMBER OF PHYSICIANS: _____ NUMBER OF LOCATIONS: _____

CERTIFICATIONS: _____

PRACTICE TYPE: Private Multi-Specialty University Affiliated Hospital Based/Owned Solo Clinical

DOES THE PRACTICE EMPLOY: RN Occupational Therapist LPN NP MA Surgical Asst PA

Hand Therapist Ortho Tech PT Radiology Tech Other: _____

DOES THE OFFICE HAVE: X-Ray Physical Therapy Ambulatory Surgery Center MRI CT Occupational Therapy

CHARTS: Electronic Paper EMR/EHR Name: _____

PMS NAME: _____

REGISTRATION FEE: \$125

PLEASE MAKE CHECKS PAYABLE TO: GAOE

CREDIT CARD PAYMENTS:

Card Type: Master Card AMEX Visa Discover

Name on Card: _____

CC #: _____ Exp. Date: _____ AVS Code (3 digit # on back): _____

Billing Address with Zip Code: _____

Mail, fax or e-mail to: Rebecca Hockaday

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