



Membership Application

Name: _____ Title: _____ Date: _____

Hospital or RETAC Affiliation: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Work Phone: (____)-_____ Fax: (____)-_____

E-mail Address: _____

Position: _____ Length of time in current position: _____

Would you like to receive a Trauma Coordinator mentorship packet? _____

Areas of special interest: _____

Membership Dues: \$60.00/year

Please make check or money order out to:
Colorado Trauma Network, Inc.

Send Membership Application to:
Colorado Trauma Network, Inc.
499 E. Hampden, Ste. 380
Englewood, CO 80113