TEXAS CHAPTER OF ORTHOPEDIC PHYSICAN ASSISTANTS

PLEASE MAKE PAYMENT TO : TCOPA

C/O **Celia Strickland 419 Justice Street Cedar Hill, Texas 75104**

NAME _____

HOME ADDRESS_____CITY_____

STATE_____ZIP CODE_____PHONE home_____CELL_____

FAX_____EMAIL _____

EMPLOYER NAME_____ADDRESS_____
CITY_____ STATE_____ZIP_____

PHONE_____DOB_____

PREFERRED METHOD OF CONTACT_____

CREDENTIALS—OPA-C, LSA, SAC, OT, RN _____

MEMBER # NBCOPA_____DATE CERTIFIED_____

TCOPA FULL MEMBERSHIP (12 Months –renewal each year in January) ----- $200

TCOPA #_____Publish Contact Information on Member Section of Website YES ☐ NO ☐

OFFICIAL USE ONLY

TEXAS CHAPTER OF ORTHOPEDIC PHYSICIAN'S ASSISTANTS

RECEIPT FOR DUES OF CHARTER MEMBERSHIP RECEIVED

AMOUNT PAID $_____

NAME _____

TCOPA #_____WEBSITE LOGIN AND PASSWORD _____

NAME OF MEMBER _____

RECEIVED BY_____DATE_____