

TEXAS CHAPTER OF ORTHOPEDIC PHYSICIAN 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) ----- \$100

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 _____