RHN
Rural Health Network of Oklahoma

Membership Application

Applicant Information

Company Name: _____

Contact Name: _____ Title: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

EIN: _____ Website: _____

Member Category: _____

Number of Physicians: _____ Number of RNs: _____ Number of Counselors: _____

Number of Employees: _____ Number of Beds: _____

Billing (if different than above)

Contact Name: _____ Title: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Please tell us about your organization: