



**American Clinical MEG Society**  
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## **CENTER MEMBERSHIP FORM**

**Center name:** \_\_\_\_\_  
**Institution:** \_\_\_\_\_  
**Address line 1:** \_\_\_\_\_  
**Address line 2:** \_\_\_\_\_  
**City, State, Zip:** \_\_\_\_\_  
**Center phone:** \_\_\_\_\_  
**Center fax:** \_\_\_\_\_  
**Center e-mail:** \_\_\_\_\_  
**Center web:** \_\_\_\_\_

### **Center Leadership With An Automatic Membership**

1. **Name and title:** \_\_\_\_\_  
**Role in the center:** \_\_\_\_\_  
**Contact info:** \_\_\_\_\_  
\_\_\_\_\_

2. **Name and title:** \_\_\_\_\_  
**Role in the center:** \_\_\_\_\_  
**Contact info:** \_\_\_\_\_  
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