



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: _____
