



American Clinical **MEG** Society (ACMEGS)

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2018 Center Membership Form

Center Information:

Mailing:

Center Name: _____

Contact Name: _____

Address: _____

City, State, ZIP: _____ Phone: _____

Email: _____ Fax: _____

Website: _____

Directory (if different from above):

Contact Name: _____

Address: _____

City, State, ZIP: _____ Phone: _____

Email: _____ Fax: _____

Website: _____

Two Members Included in Center Membership:

Member 1:

Primary Billing Contact: Yes No

Name: _____

Position: _____

Address (if different than above):

Phone: _____

Email: _____

Member 2:

Primary Billing Contact: Yes No

Name: _____

Position: _____

Address (if different than above):

City, State, ZIP: _____

Phone: _____

Email: _____

Name of Billing Contact (if not listed above): _____

Phone: _____ Email: _____

Name of MEG Center Director: _____

Phone: _____ Email: _____

Name of Chief Technologist: _____

Phone: _____ Email: _____

Please pay by credit card below or include a check payable to ACMEGS.

Center Membership Fee: \$2,000.00 per year

Check enclosed

Visa Mastercard Account #: _____ Exp. Date: _____

Authorized Signature: _____