American Clinical MEG Society (ACMEGS)

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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):
_____
City, State, ZIP: _____
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: $2,500.00 per year
□ Check enclosed
□ Visa □ MC □ AmEx Account #: _____ Exp. Date: _____
Authorized Signature: _____