

Guilford Medical & Dental Managers

APPLICATION FOR ASSOCIATE MEMBERSHIP

NAME _____ POSITION _____

EMPLOYER _____

ADDRESS _____

CITY, STATE, ZIP _____

PHONE _____ FAX _____

EMAIL _____

PLEASE LIST THE NAMES OF 3 CURRENT GMDM ACTIVE OR ASSOCIATE MEMBERS WHO KNOW YOU PERSONALLY AND CAN RECOMMEND YOU FOR MEMBERSHIP IN GMDM: _____

WHAT BENEFITS DO YOU FEEL YOU WILL RECEIVE FROM MEMBERSHIP IN GMDM? _____

WHAT BENEFITS ARE YOU ABLE TO OFFER GMDM? _____

Associate membership: \$395 per year

Do not pay now. All applications must be approved by the GMDM Board; limited spaces available.

Please return your completed application to us at gmdmboard@gmail.com.

*** All Associate Members Must Sign Up for a Committee ***

Committee descriptions are listed under "About Us" on our website at www.gmdm.org.

Membership Outreach _____ Collaborative Events _____ Education _____ Golf _____ Social Media _____

Scholarships _____ Community Service _____ Annual Recognition _____ Communications _____