CACMLE
Colorado Association For Continuing Medical Laboratory Education, Inc.

Membership Application

(Please Print)

_____

Last Name First Middle Initial

_____

Department (If not a home address)

_____

Institution (If not a home address)

_____

Address ❒ This is my home address. Please send all correspondence to my home.

_____

City State Country Zip+4 (Postal Code)

_____

e-mail address (we need email for your newsletter)

(_____) _____ _____ (_____) _____

Daytime Phone # Extension Fax

Please accept my application for the following:

Membership Description :	Unit Price
❒ Basic Individual Membership	$25.00
❒ Auto Renew Annually w/this credit card	
❒ Aesculapius Donor Membership	$100.00
❒ Please accept my additional donation of	$____

Total Payment Enclosed: _____

Payment enclosed as follows **Payable to CACMLE** (Sorry, we do not accept purchase orders.):

Check/Money Order Check #_____

❒ Visa ❒ Mastercard ❒ American Express ❒ Discover

_____

Credit Card # Security Code #

_____

Name on Card

_____

Expires Signature

Return to: **CACMLE.** 6825 E Tennessee Ave, Ste 111, Denver CO 80224-1629
phone: (303) 321-1734 * fax: (303) 321-9231 * email: info@CACMLE.org