



VENDOR DIRECTORY ENROLLMENT FORM

Business Name: _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Contact Name: _____ **Title:** _____

Phone: _____ **Ext#** _____ **Cell:** _____ **FAX:** _____

E-Mail Address: _____

Website Address: <http://www.> _____

Business Description, Products & Services Offered (50 words or less):

Categories Which Your Business Should Be Listed (maximum 3):

- | | |
|--|--|
| <input type="checkbox"/> Billing, Coding, & Collection | <input type="checkbox"/> Human Resources, Benefits, Staffing |
| <input type="checkbox"/> Business Insurance | <input type="checkbox"/> Medical & Lab Equip. & Supplies |
| <input type="checkbox"/> Computers: Software, Networks,
Internet, Scanners | <input type="checkbox"/> Office Products, Supplies & Equipment |
| <input type="checkbox"/> Consulting: Practice Mgmt.,
Compliance, Security, Risk Mgmt,
Legal Services | <input type="checkbox"/> Pharmaceuticals |
| <input type="checkbox"/> Finance, Banking, Accounting, Payroll | <input type="checkbox"/> Telecom Equipment & Services |
| | <input type="checkbox"/> Travel, Catering, Entertainment |
| | <input type="checkbox"/> Uniforms & Laundry |
| | <input type="checkbox"/> Other |

1. CMGMA GENERAL MEMBER References

First Name: _____ **Last Name:** _____

Practice Name: _____

Title: _____ **Phone:** _____ **Ext#** _____

E-Mail Address: _____

Referring Member must send a confirming email to CMGMA at info@cmgma.org

2. CMGMA GENERAL MEMBER References

First Name: _____ **Last Name:** _____

Practice Name: _____

Title: _____ **Phone:** _____ **Ext#** _____

E-Mail Address: _____

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3. CMGMA GENERAL MEMBER References

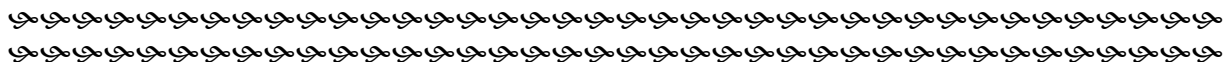
First Name: _____ **Last Name:** _____

Practice Name: _____

Title: _____ **Phone:** _____ **Ext#** _____

E-Mail Address: _____

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Vendor Directory: **\$300/year Non Member** **\$100/year Member**

Payment Information:

*** By check, please make checks payable to CMGMA**

Mail to: One Regency Drive, P.O. Box 30, Bloomfield, CT 06002

*** By credit card: Please fax registration to: (860) 286-0787**

Card Type **Mastercard** **VISA** **American Express**

Card Number: _____ **Expiration Date** _____

Name on Card: _____