CONNECTICUT MEDICAL GROUP MANAGEMENT ASSOCIATION

2011 SALARY SURVEY ORDER FORM

Please complete the following and remit with payment to CMGMA, One Regency Drive, Bloomfield, CT 06002 or fax to: 860-286-0787.

Name ____
Title____
Place of Employment ____
Address____
City/State/Zip____
Phone Number________________________ Fax Number_________________
Email Address____

Please Check one:

☐ Electronic Version ☐ Printed Copy

Payment
___$100 – Member who did not participate in survey
If you did not participate please tell us why. Your answer will be kept confidential and will only be used to help us increase participation in 2012/2013.____
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___$175 – Nonmember who did not participate in *survey* ***(includes a one year free membership – first time members only).***
____Yes, I do wish to become a CMGMA Member.
____No thank you, I do not wish to become a CMGMA Member at this time.

Amount Paid $__________
☐ Check Enclosed #_________(please make check payable to CMGMA)
☐ Credit Card #_________________________________Expiration Date ______________
_____AMEX _____MasterCard _____VISA
Name on Card:___________________________ Signature:____________________________

Fee is nonrefundable.

For more information please contact CMGMA at info@cmgma.org or CMGMA Executive Office (860) 243-3977.