

CONNECTICUT MEDICAL GROUP MANAGEMENT ASSOCIATION

2009 SALARY SURVEY ORDER FORM

Please complete the following and remit with payment to CMGMA, One Regency Drive, Bloomfield, CT 06002.

Name _____
Address _____
Phone Number _____ Fax Number _____
Email Address _____
Place of Employment _____

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 2010. _____

___ \$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.

Check Enclosed # _____ (please make check payable to CMGMA)
Amount \$ _____
Credit Card # _____
Expiration Date _____ Amount \$ _____
___ 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.**