



Colorado Alliance for Continuing Medical Education
PO Box 103012, Denver CO 80250

2010 MEMBERSHIP APPLICATION

Name: _____

Company: _____

Mailing Address: _____

Email Address: _____

Phone: _____ Fax: _____

Former Member: YES: _____ NO: _____ YEAR: _____

Endorsed By (Optional): _____

MEMBERSHIP DUES

Individual Membership	\$95
Organization Membership*	\$95 - First Member
	\$70 - Each Additional Member

*If there are multiple members in your organization, please be sure to fill out a form for each member.

Please check the type of membership that applies to you:

_____ 1 / Individual	\$95
_____ 1 / Organization	\$95
_____ 2 / Organization	\$165
_____ 3 / Organization	\$235

Total Amount Enclosed: \$ _____

Please make checks payable to:

CACME
PO Box 103012
Denver CO 80250