

COGS - Coalition of Geriatric Services
Membership Application

Organization: _____	Date _____		
Address: _____	City _____	ST _____	Zip _____
Telephone: _____	Fax: _____	Web Site: _____	

Are you a New Member _____ or Are you Renewing Your Membership _____

Representative(s) Note: Representative No. 1 Name and title will be main contact person billing and directory.

1. Name _____ Title _____

Email: _____

2. Name _____ Title _____

Email: _____

3. Name _____ Title _____

Email: _____

4. Name _____ Title _____

Email: _____

Description of organization/business activity (20-25 words):

Membership Dues Schedule (please check one):

- _____ \$ 2,500 Platinum Sponsor
- _____ \$ 1,500 Gold Sponsor
- _____ \$ 1,000 Silver Sponsor
- _____ \$ 500 Bronze Sponsor
- _____ \$ 300 Patron
- _____ \$ 100 Member

Mail check payable to: COGS, P.O. Box 2131, Ellicott City, MD 21041

Telephone: 410-997-0610 Fax: 410-549-2516 Email: info@cogsmd.org