HOSPITAL Membership Application & Dues Invoice

Membership dues shall be returned to the IGFS office at the address listed in the box on the right.

Hospital Membership Dues:

Hospital Membership: **$2,000**

TOTAL DUES ENCLOSED:_____

IGFS, Inc.
1215 E Robinson Street
Orlando, FL 32801
Office: 813-909-0450
FAX: 813-949-8994
Email: igfs@cobbemanagement.com

Hospital Membership provides the opportunity for a hospital to become a member of the organization and identify your Geriatric Fracture Care Program Coordinator and 4 members of the facility staff to receive education and benefits of membership in the IGFS.

Database Information: (Please complete the information below.)

Hospital Name: _____
Membership Classification: *Hospital Member*
Main Office Address: _____
_____
_____
Main Office Telephone: _____
Main Office Fax: _____

On the next page please list the Name and requested information for up to 5 Staff Members who shall receive correspondence from the IGFS.

Payment Information:
Enclosed please find my check made payable to the "International Geriatric Fracture Society".

I hereby authorize the following amount to be charged to my credit card. Amount: _____

Card #: _____ Expiration Date: _____
(Visa or Mastercard or AMEX)

Security Code: _____ Billing Zip Code: _____

Name as it appears on card: _____

Billing Address if different from above: _____

Credit Card payments may be faxed to: 813-949-8994 or scanned and emailed to: igfs@cobbemanagement.com.

Please Note: Dues are not deductible as a charitable expense but they may be deductible as a business expense according to the IRS.

0% of your dues were used for direct lobbying expense. As a result 100% of IGFS membership dues can be deducted as a business expense.

Please provide the names of your Geriatric Fracture Care Program Coordinator and up to four staff members from your hospital that you would like to register with the IGFS.

Program Coordinator: _____
E-Mail Address: (required) _____
Position or Title: _____

Staff Name Number 1: _____
E-Mail Address: (required) _____
Position or Title: _____

Staff Name Number 2: _____
E-Mail Address: (required) _____
Position or Title: _____

Staff Name Number 3: _____
E-Mail Address: (required) _____
Position or Title: _____

Staff Name Number 4: _____
E-Mail Address: (required) _____
Position or Title: _____

Please return both pages to the IGFS office using the information provided below.

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