Georgia Transplant Foundation
Enriching Lives Everyday

MEMBERSHIP REGISTRATION FORM
COMMUNITY PARTNER GROUP

Name	
Street Address	
City, State, Zip Code	
Phone Number	
E-Mail Address	

Desired Community Group (please check one):

___ Atlanta/Buckhead ___ Alpharetta/Roswell/Johns Creek ___ Savannah

___ Dunwoody/Sandy Springs ___ Athens ___ Other (please list) _____

How did you hear about the Georgia Transplant Foundation?

Why would you like to become a member of a Community Partner Group?

Please list any unique skills or talents you possess:

___ I agree to represent the Georgia Transplant Foundation in a respectful and professional manner.

___ I will participate in all Community Partner Group meetings and fundraisers, to the best of my ability.

_____ _____

Signature *Date*

Please complete and return this form to Cheryl Belair by fax: 770-457-7916 or email: cbelair@gatransplant.org