

RETURN CARD

New York Weill Cornell Medical Center Alumni Council

YES, I'd like to join The New York Weill
Cornell Medical Center Alumni Council

Name _____

Home Address _____

City _____

State _____ Zip _____ Phone Number _____

Name of Spouse/Partner/Significant Other _____

- Yearly Membership Fee: \$65.00 (January – December)
- First three years after completing postgraduate education
or fellowship: \$15.00
- Retiree: Complimentary lifetime membership
- Housestaff: First year complimentary membership

Amount enclosed \$ _____

Please make check payable to: **NYWCMC Alumni Council**

Please charge my (*check one*):

- Visa Mastercard American Express

Account Number: _____

Expiration Date: _____
Month Year

Name of Cardholder (*please print*): _____

Cardholder's signature: _____

(please complete the reverse side also)

Please tell us more about yourself:

Professional Title: _____

Special Area of Interest/Expertise:

Business/Practice Name _____

Address _____

City _____

State: _____ Zip _____

Phone Number _____

Fax Number _____

Email _____

Preferred Mailing Address (please check one):

- Home Business

Significant Professional Activities and Accomplishments:

Years at New York Hospital/Weill Cornell: _____

Would you like to be included in a future directory?

- Yes No

(please complete the reverse side also)