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Membership Form							
Payment for the year 20__				Account # _____			
Please Check one:		<input type="checkbox"/> Family \$300.00		<input type="checkbox"/> Individual \$150.00		<input type="checkbox"/> Student \$10.00	
Member Information							
First Name	M	Last Name	Profession	Work Phone	Home Phone	E-mail	Optional:DOB MM/DD/YYYY
Member:							
Spouse:							
Child 1:							
Child 2:							
Child 3:							
Additional information:							
Home Address:							
Address				City	State	Zip	
Would you like to be placed on ICGT mailing list? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Payment:							
Date:		Check #:			Amount: \$		
Date:		Cash Receipt #:			Amount: \$		
Credit Card Payment:							
Card Type: <input type="checkbox"/> VISA <input type="checkbox"/> Master Card <input type="checkbox"/> Discover <input type="checkbox"/> American Express							
Name on Card:							
Card Number:							
Security Code:		Expiration Date:		Month:	Year:		
Address:		Street	City		State	Zip	
Amount :		\$	For:				
Signature:							