



# Community of Professionals

## Application

Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Website: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

2<sup>nd</sup> Contact Person: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### PAYMENT INFORMATION

Check in the amount of \$2500 payable to Spokane County Medical Society.

Credit Card

VISA

MasterCard

Credit Card # \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Name on Card: \_\_\_\_\_

Billing address if different from above: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Send the payment and application to: SCMS – Community of Professionals  
Orange Flag Building  
104 South Freya Street, Suite 114  
Spokane, WA 99202-4868