CLA ALLIED MEMBERSHIP APPLICATION

Company Name:_____

Contact Name:_____

Title:_____

Address:_____

City:_____ State:_____ Zip:_____

Telephone:_____ Fax:_____

Website:_____ E-Mail:_____

Company Description (Maximum 30 words):

_____

_____

_____

_____

Membership Dues: **$300.00**

Total Membership Fee Due: **$_____**

__ Find check payable to: CLA

__ Bill my credit card: __ MC __ VISA __ AMEX

CC#:_____

Exp.:_____ Signature:_____

Mail or fax application with payment to CLA, 169 Orange St., New Haven, CT 06510 fax 860-659-8772.